

STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: May 18, 2018

AGENCY: MAP

FH #: 7759732J

In the Matter of the Appeal of	:
	: DECISION
	AFTER
	: FAIR
	HEARING
from a determination by the New York City	:
Department of Social Services	:

JURISDICTION

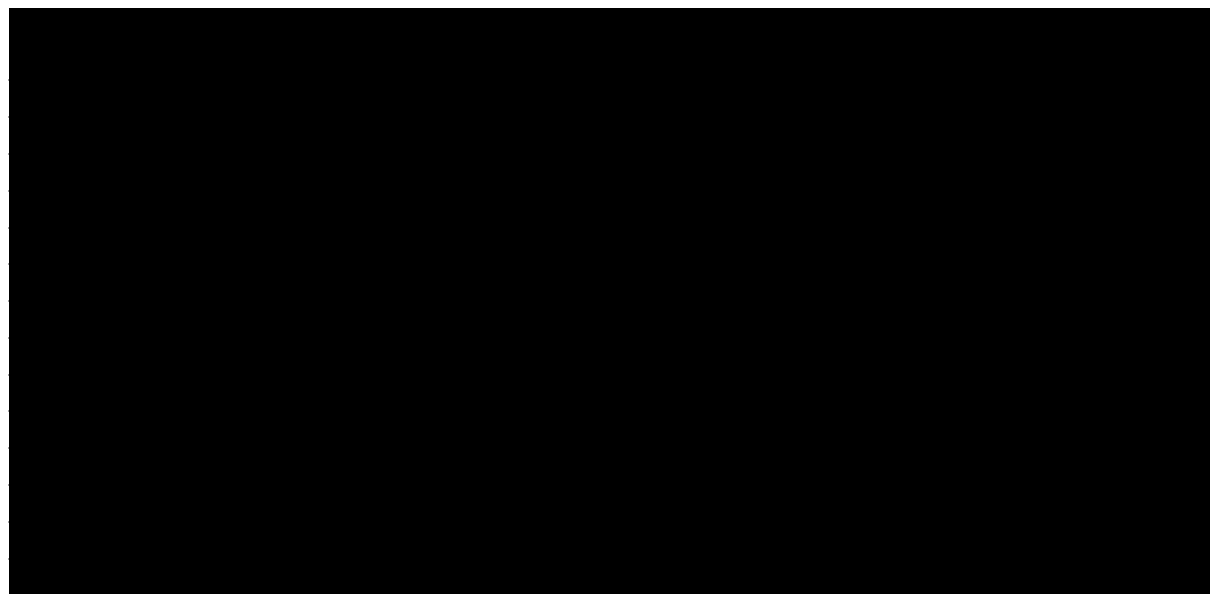
Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on June 13, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

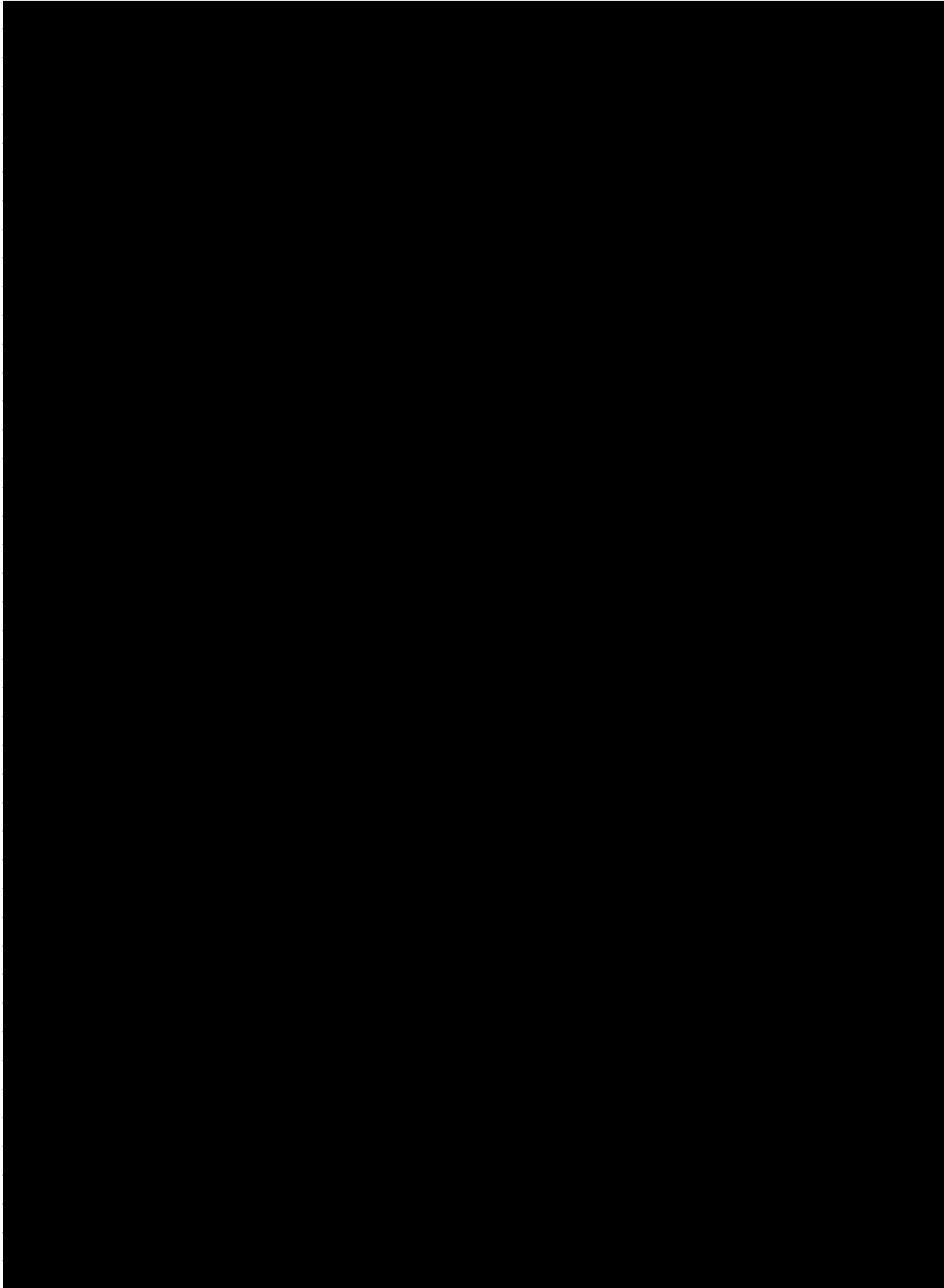


For the Long Term Managed Care Plan

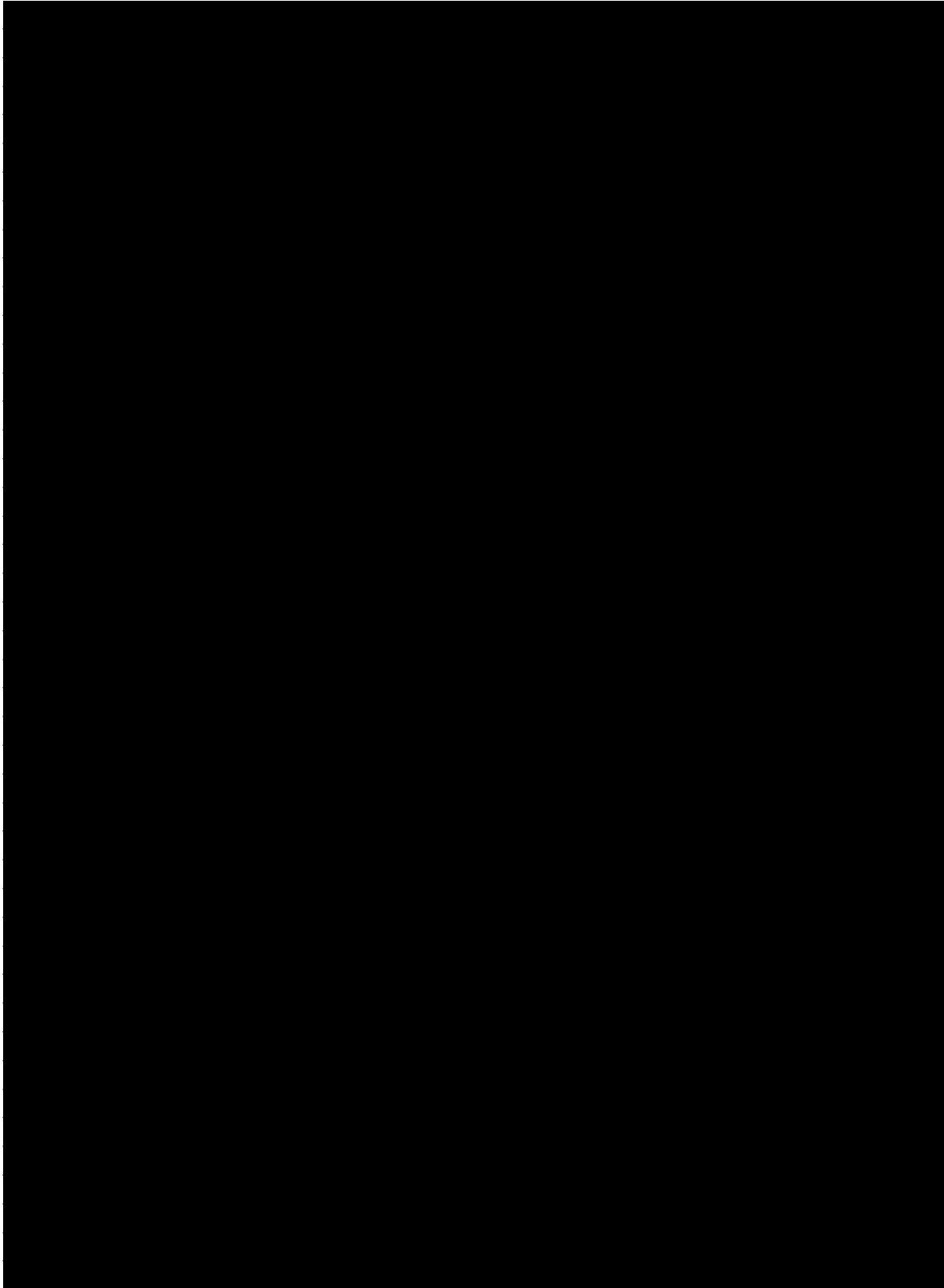
Appearance waived by the Office of Administrative Hearings



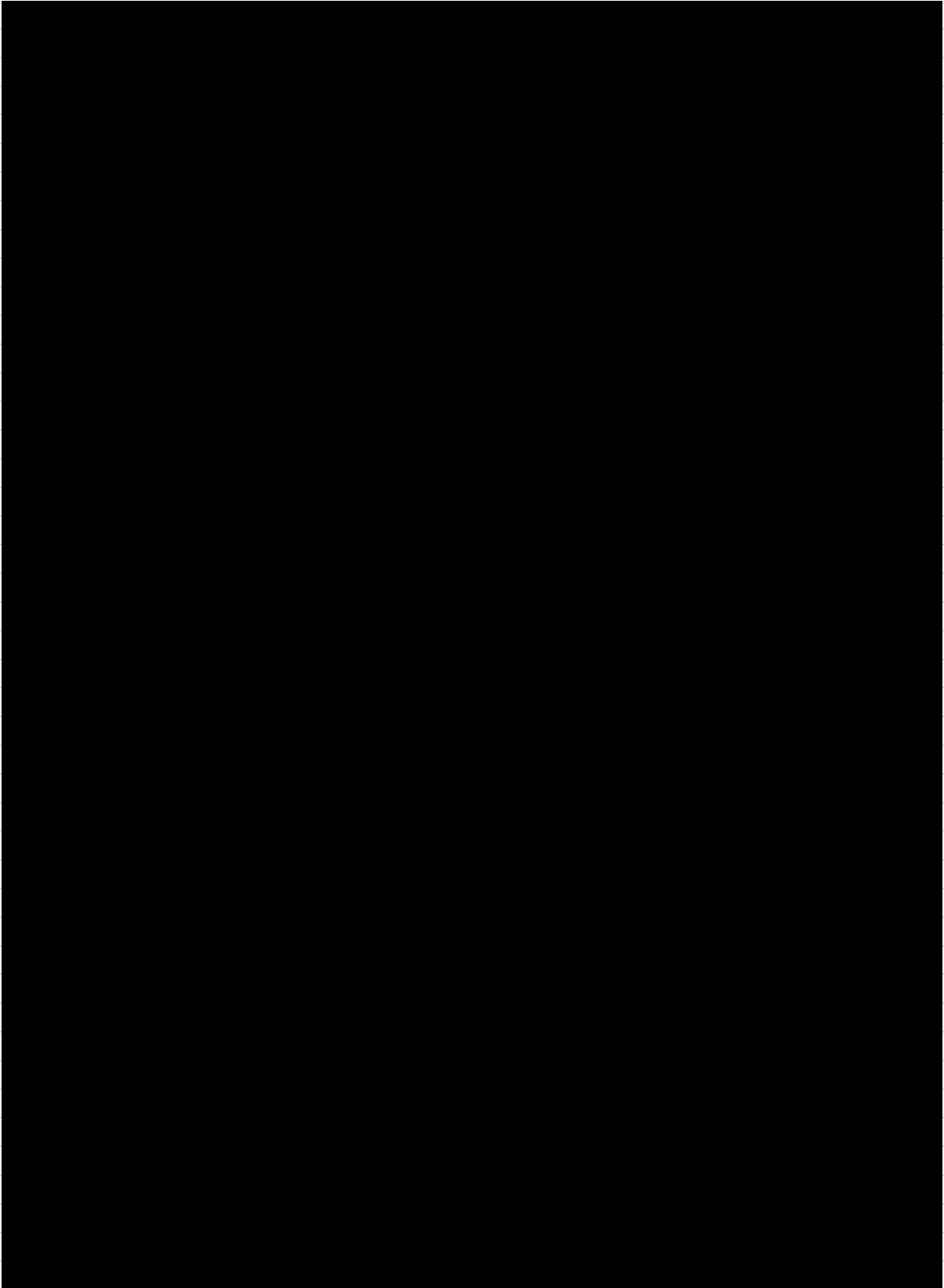
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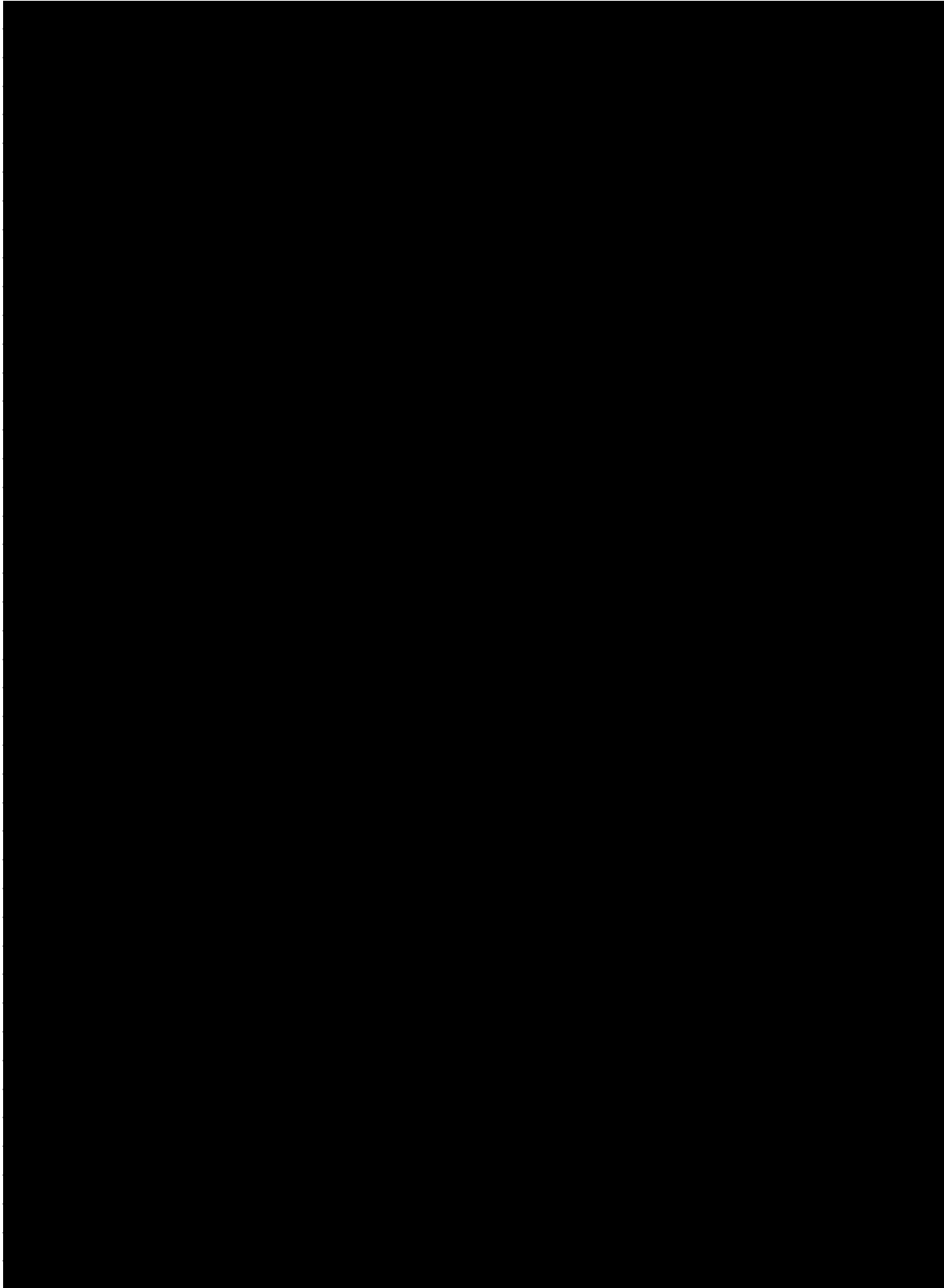
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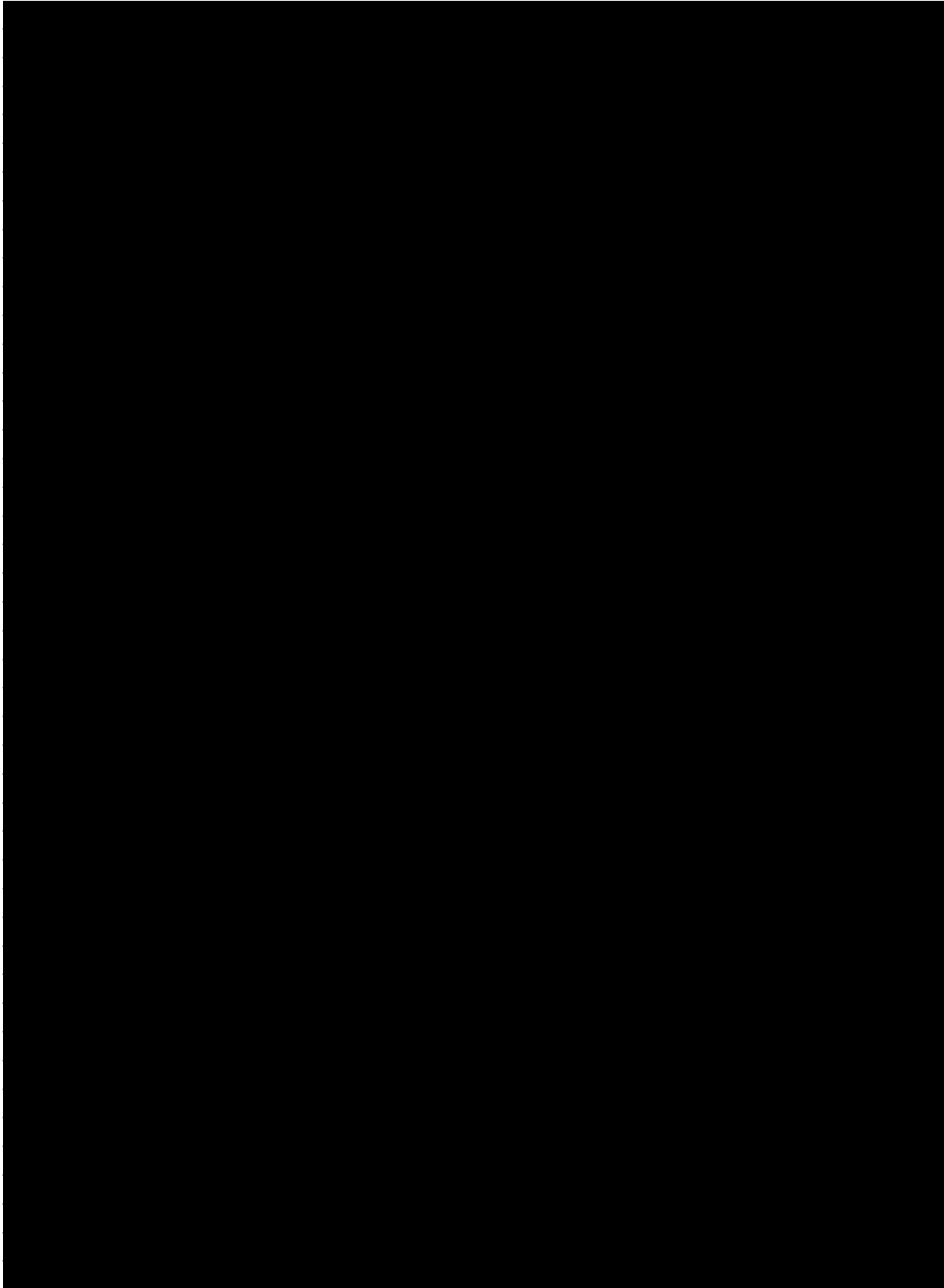


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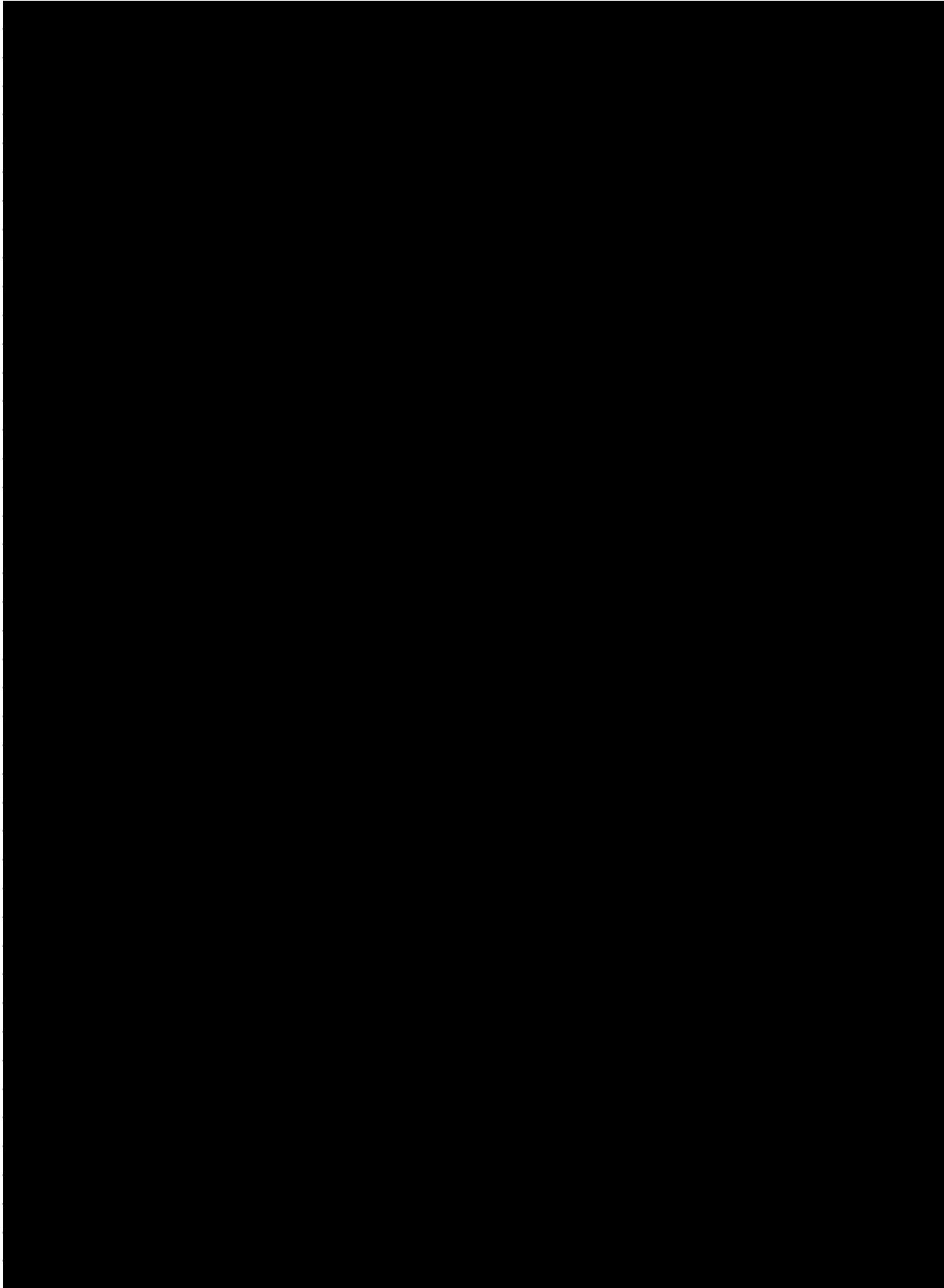


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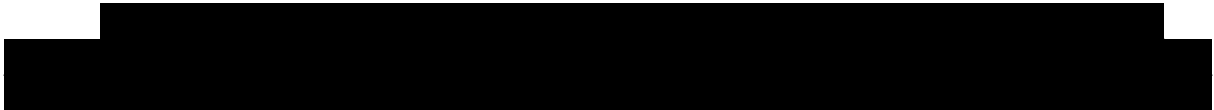
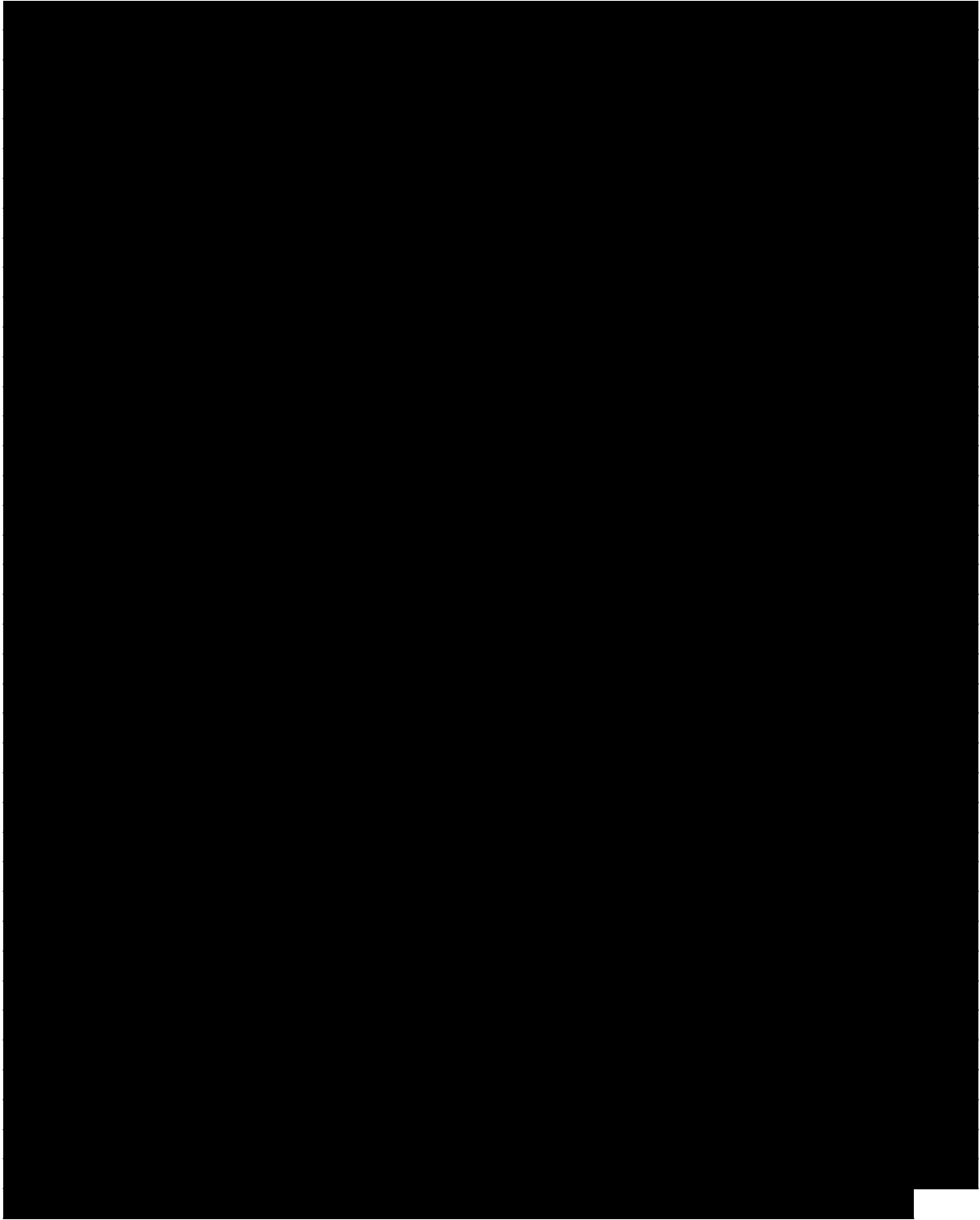




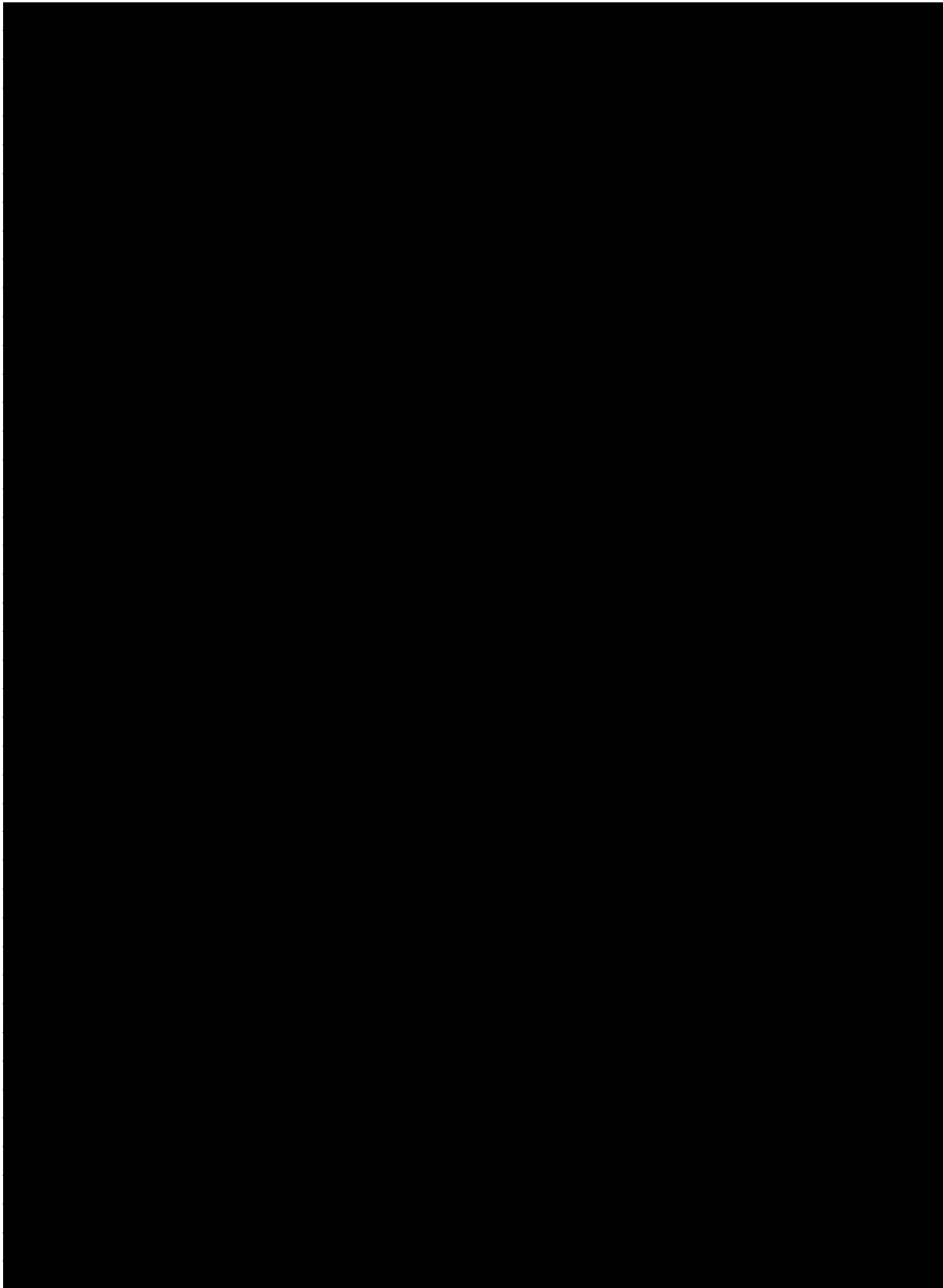
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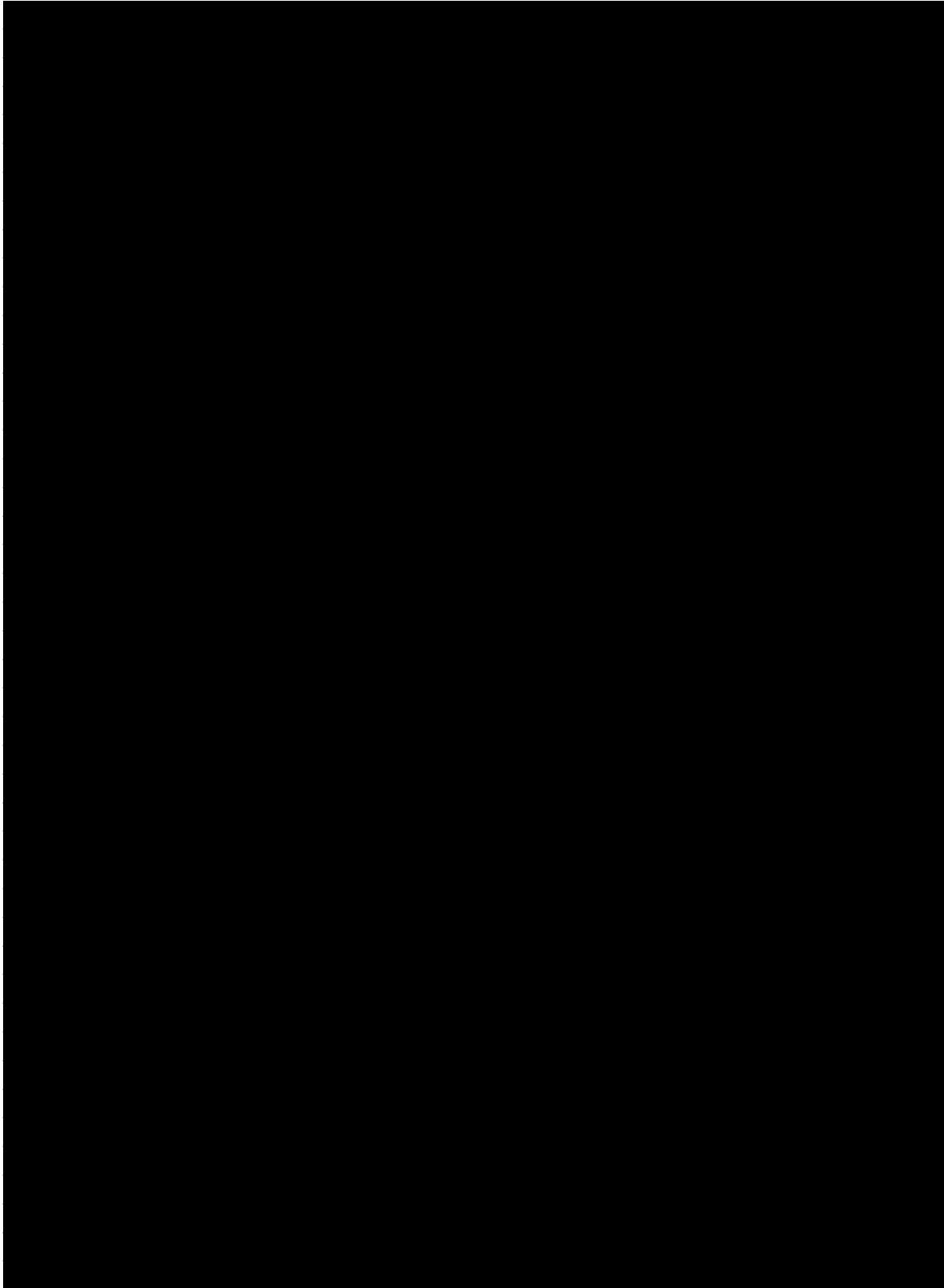


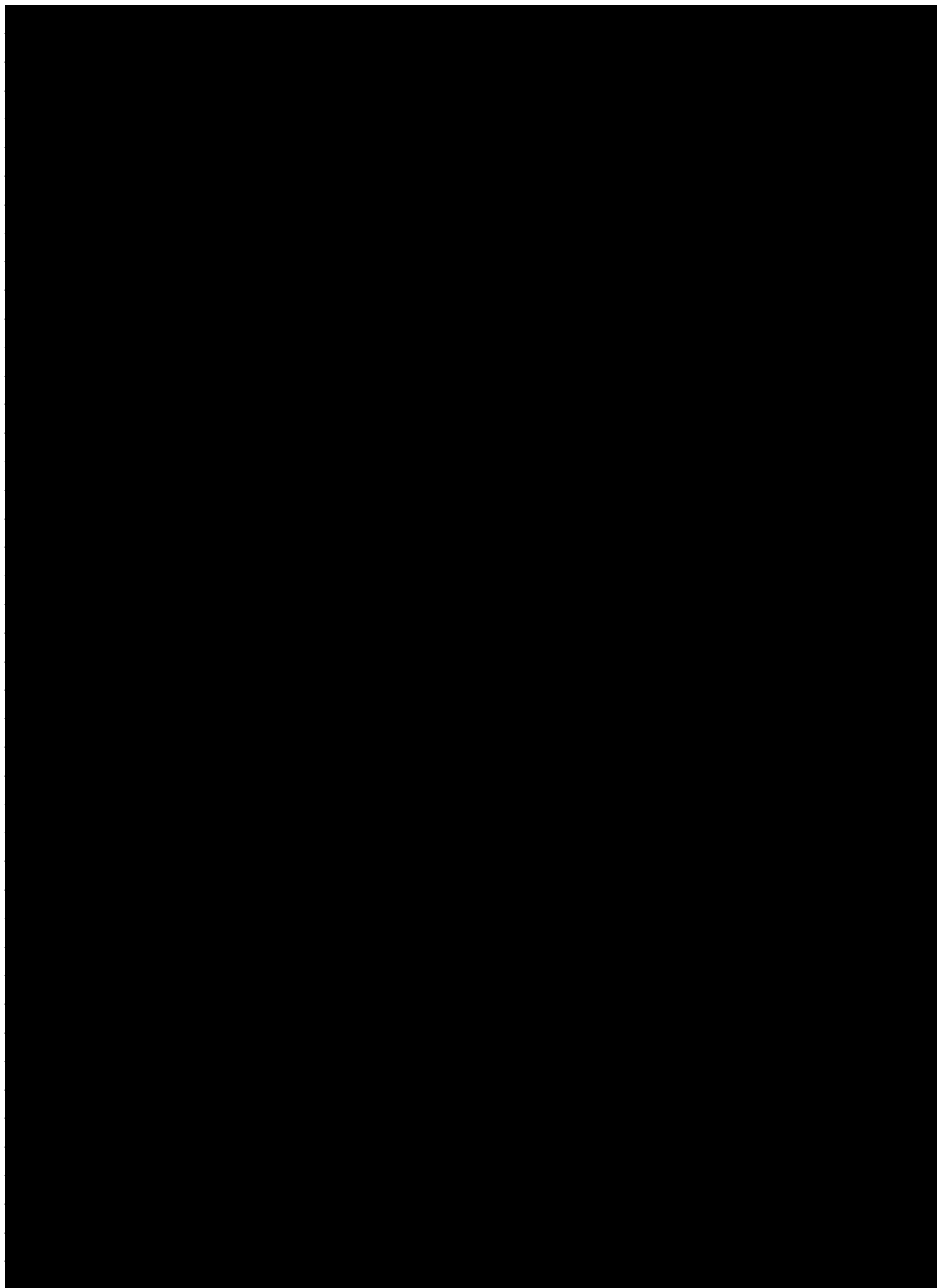
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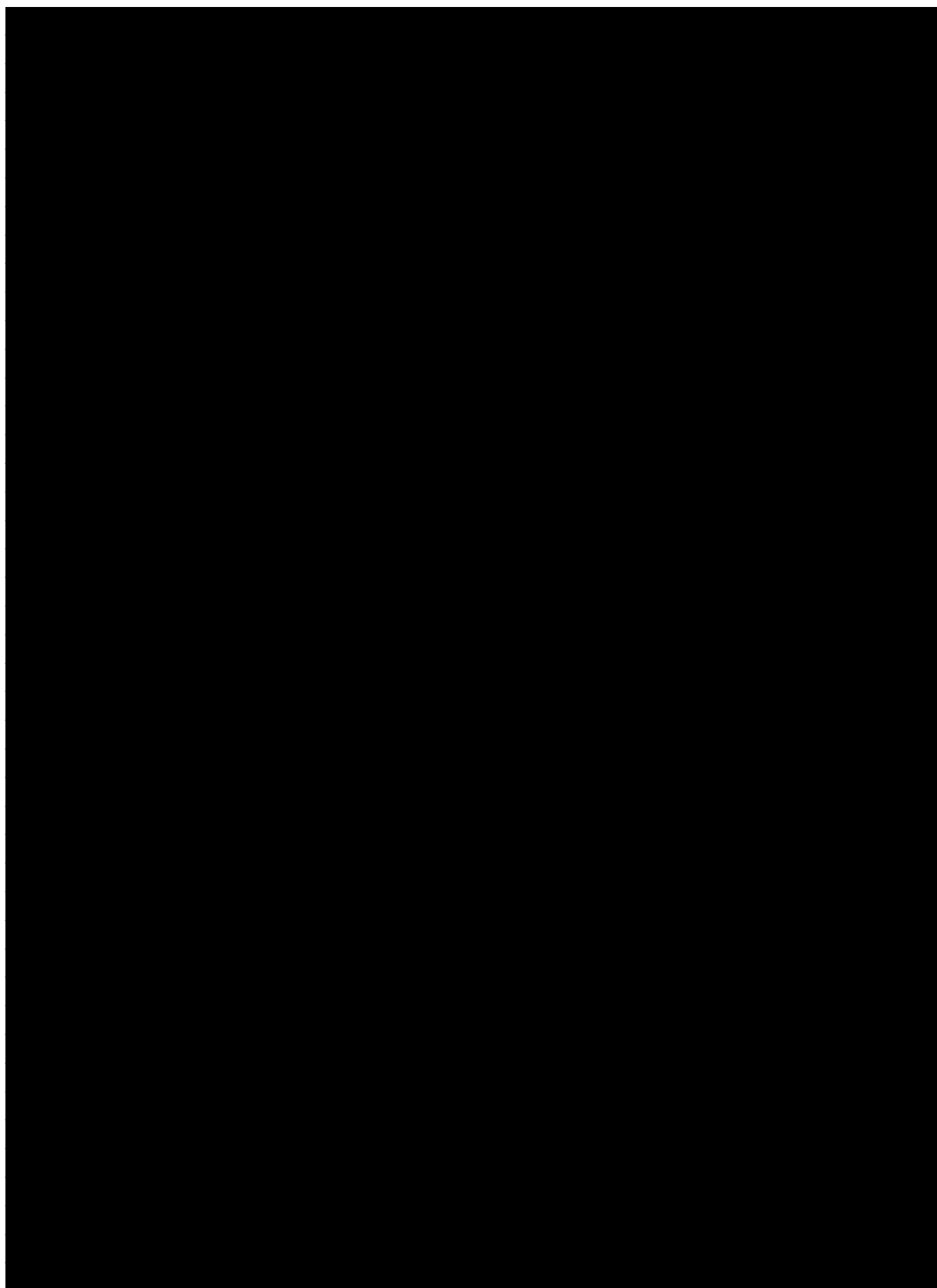


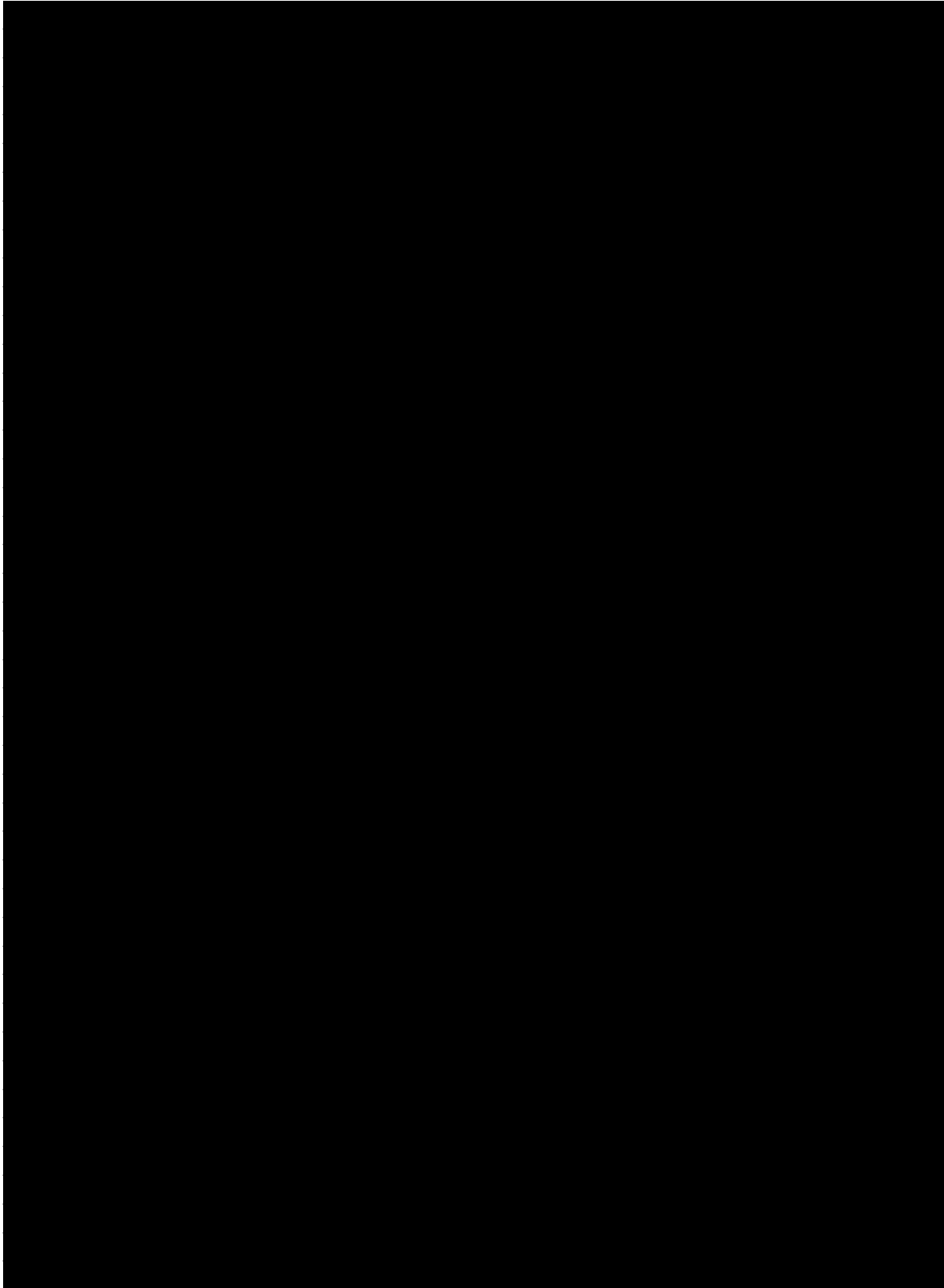
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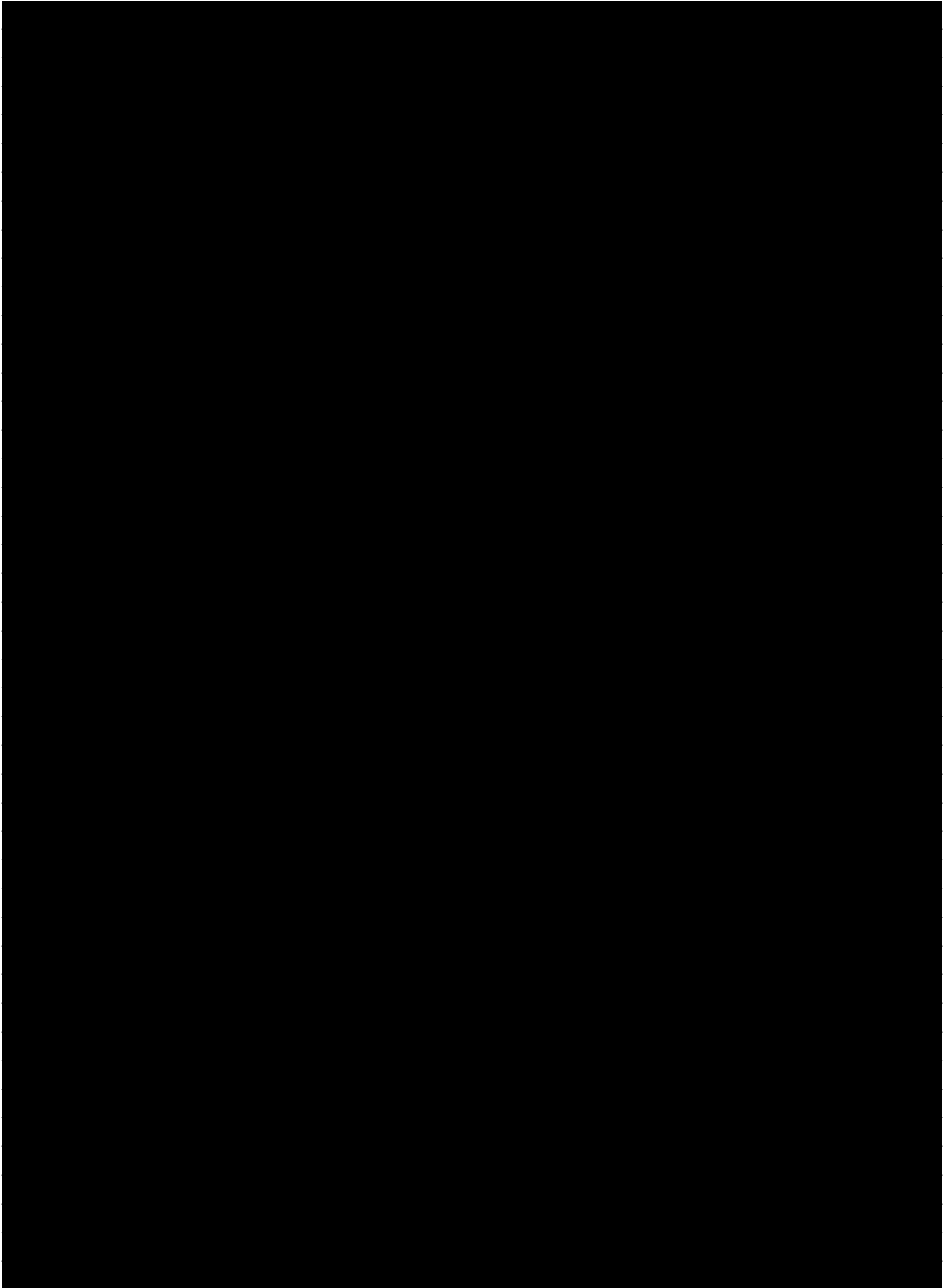


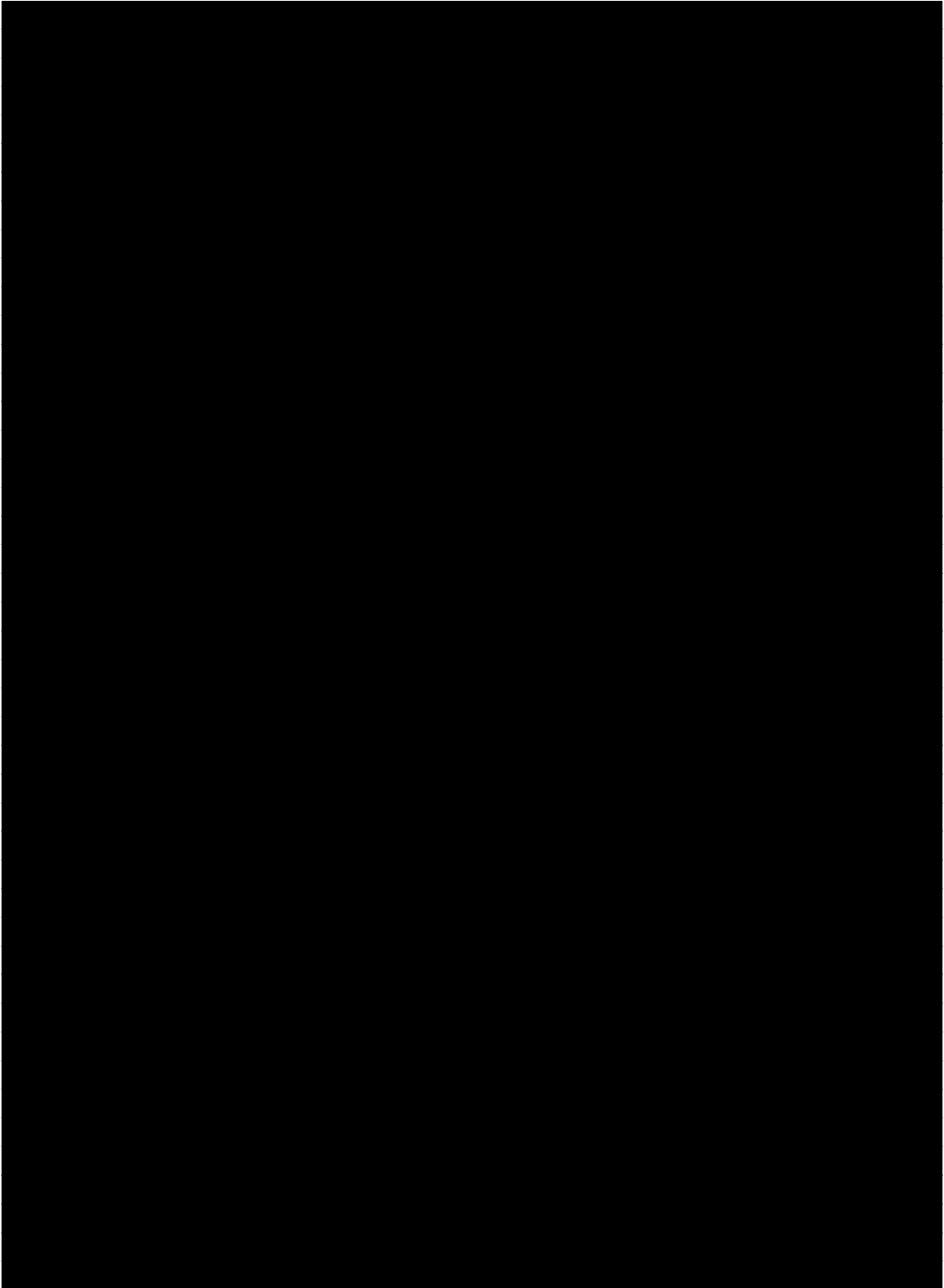






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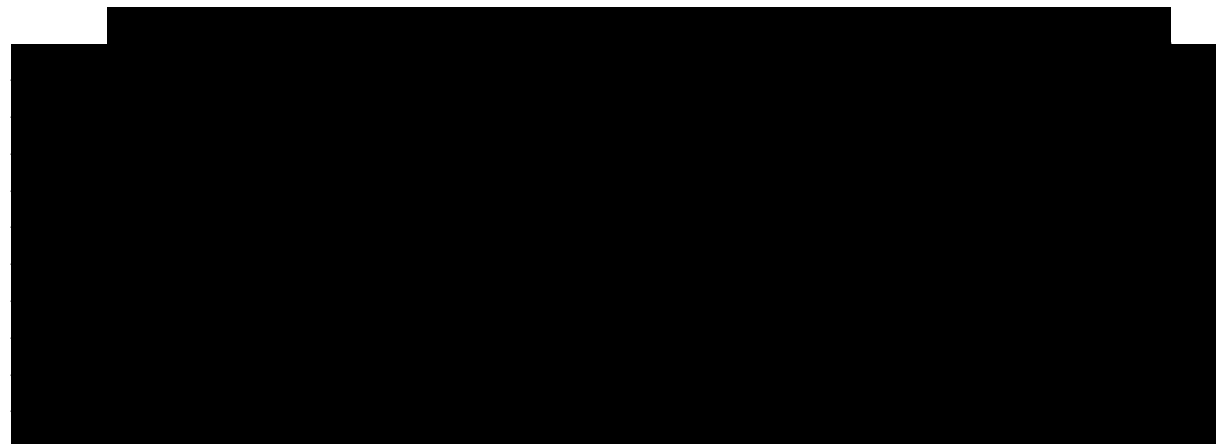
FINDINGS OF FACT

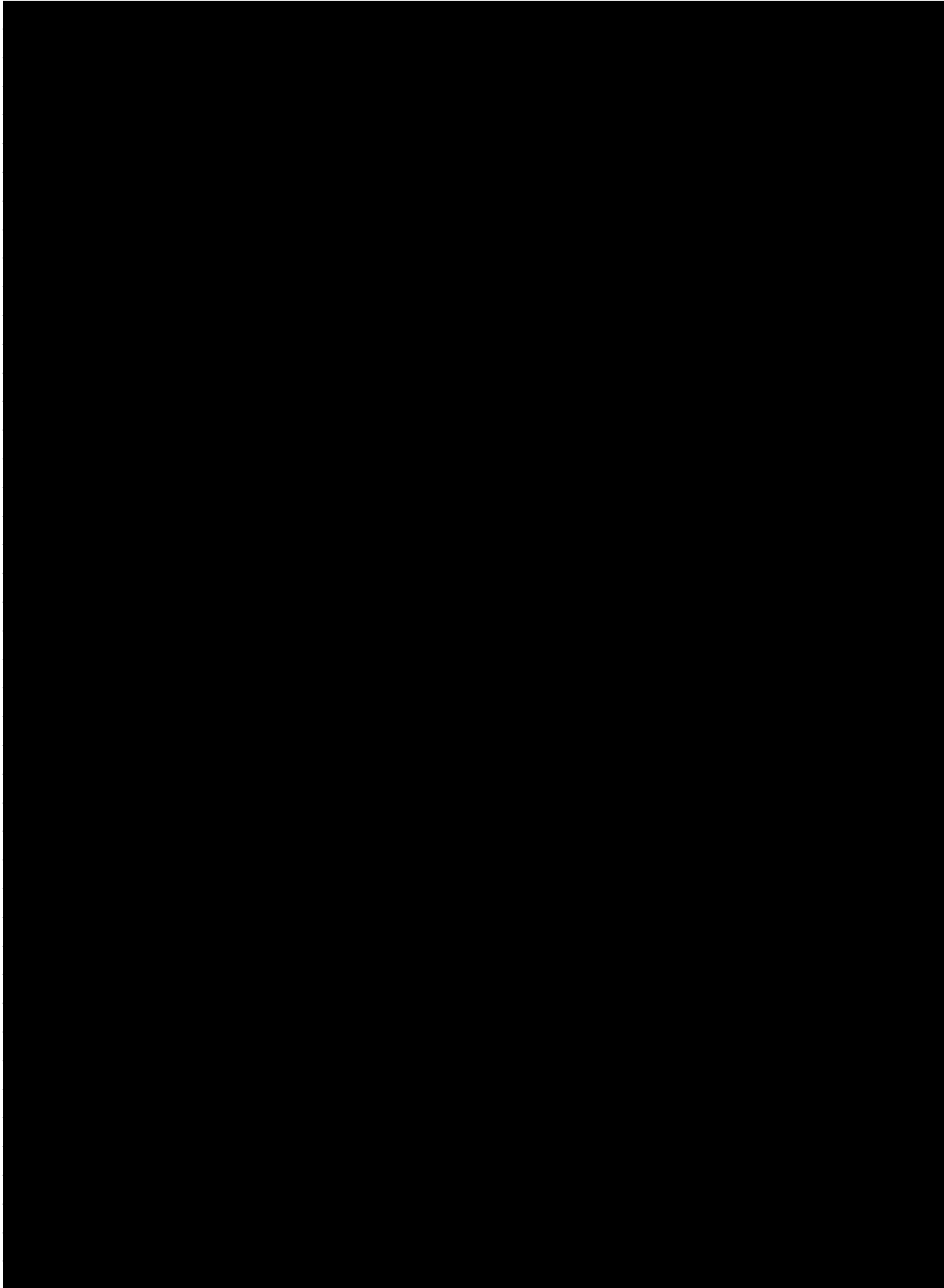
An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 82, lives alone and receives Medicaid benefits provided through a partially capitated Managed Long Term Care Plan, Centers Plan For Healthy Living, (the Plan). The Appellant is in receipt of an authorization for personal care services (PCS) in the amount of 56 hours per week (8 hours per day, 7 days per week).

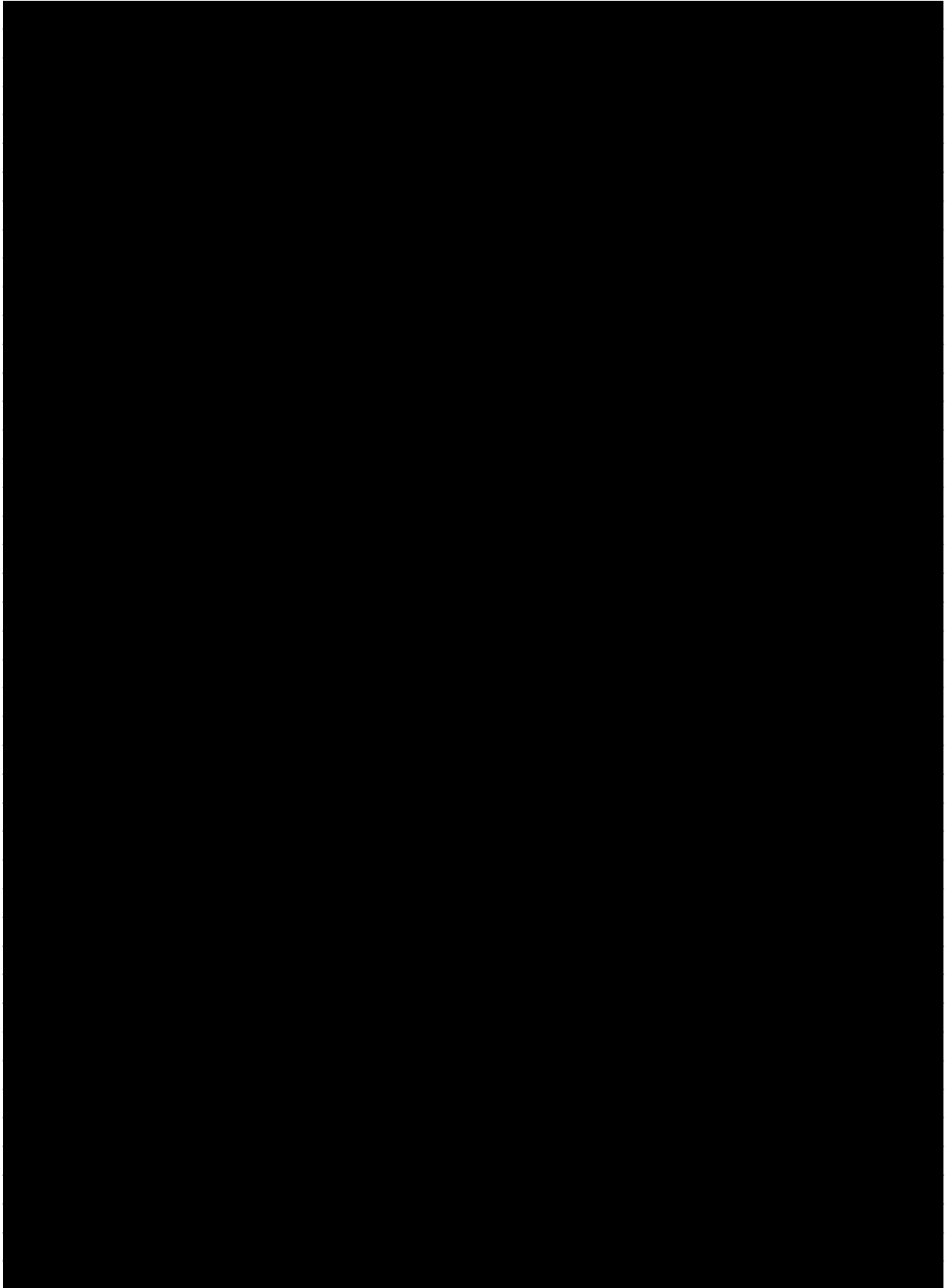
2. A Uniform Assessment System Report (UAS) evaluation on March 19, 2018 of the Appellant's personal care needs, finalized by the Plan on March 20, 2018 states the Appellant is totally dependent on others for meal preparation, housework, managing finances, managing medications, use of stairs, shopping, transportation, bathing personal hygiene, dressing upper and lower body, walking, locomotion, toilet use, and toilet transfer; she requires either maximal or extensive assistance with bed mobility, eating, and phone use. The UAS also states that the Appellant is incontinent of bladder, occasionally incontinent of bowel, and she has a severe cognitive impairment.

3. The Appellant requested that that her PCS hours be increased to 24 hour continuous care (split shift), 7 days per week.

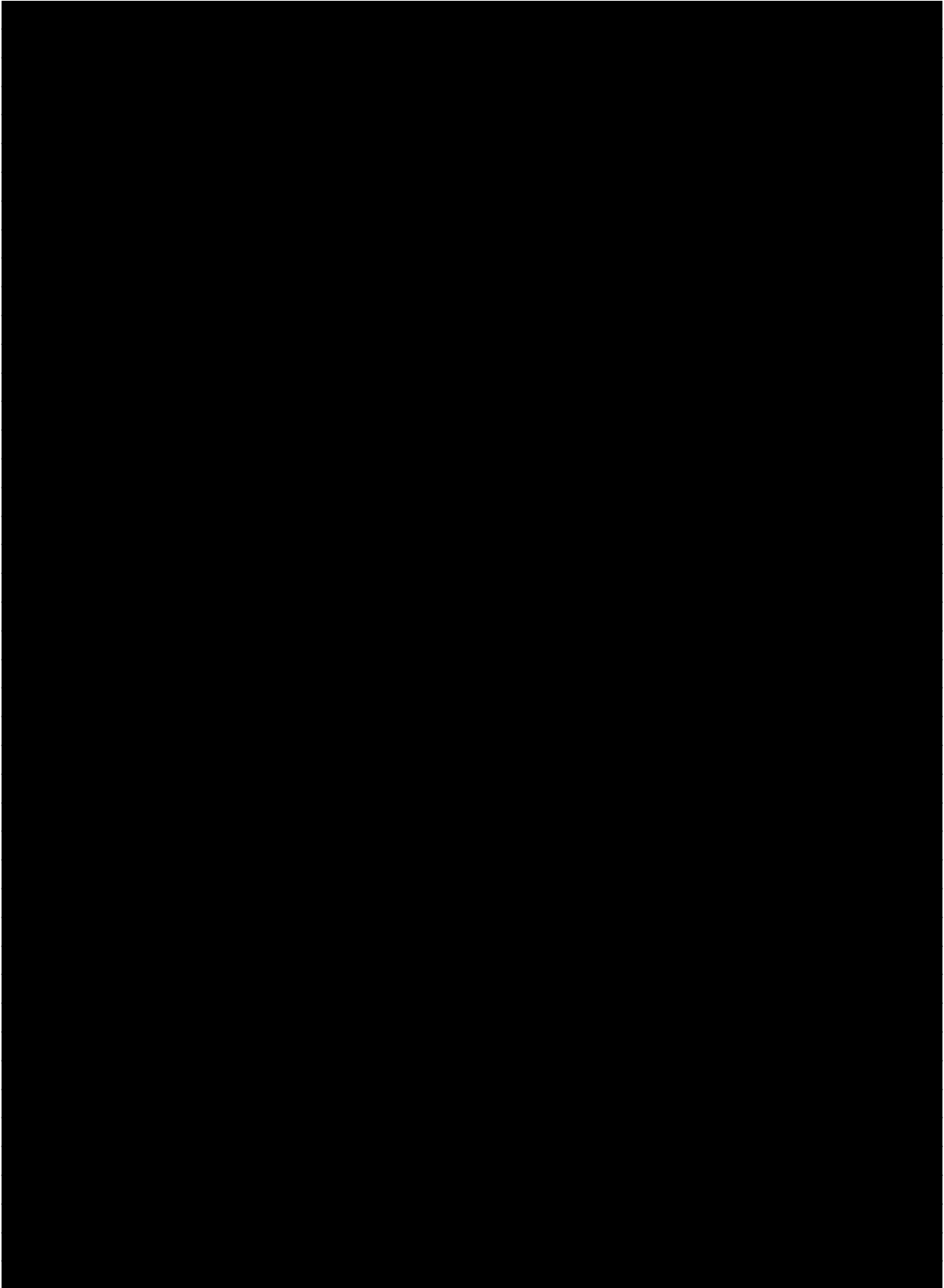


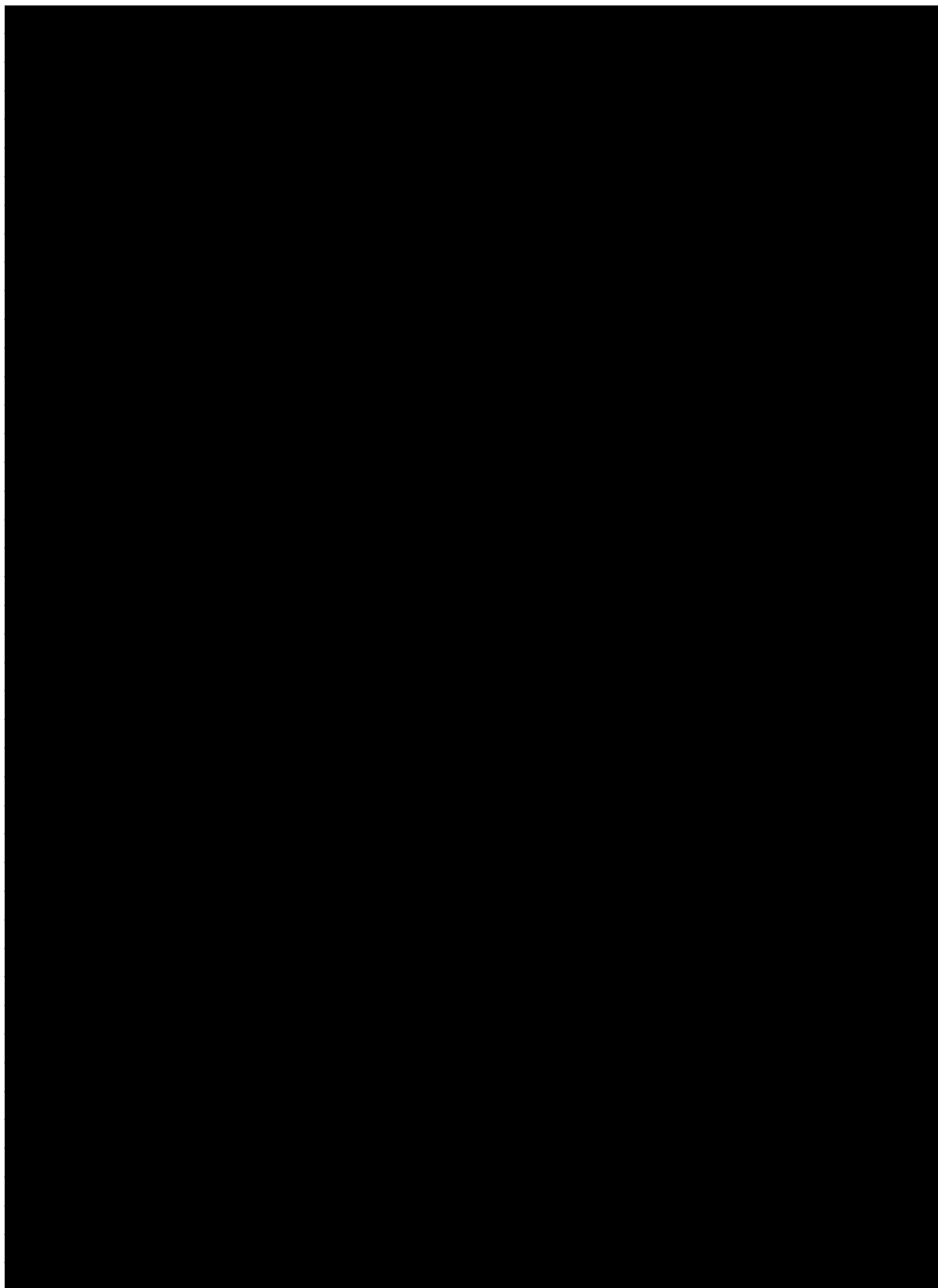


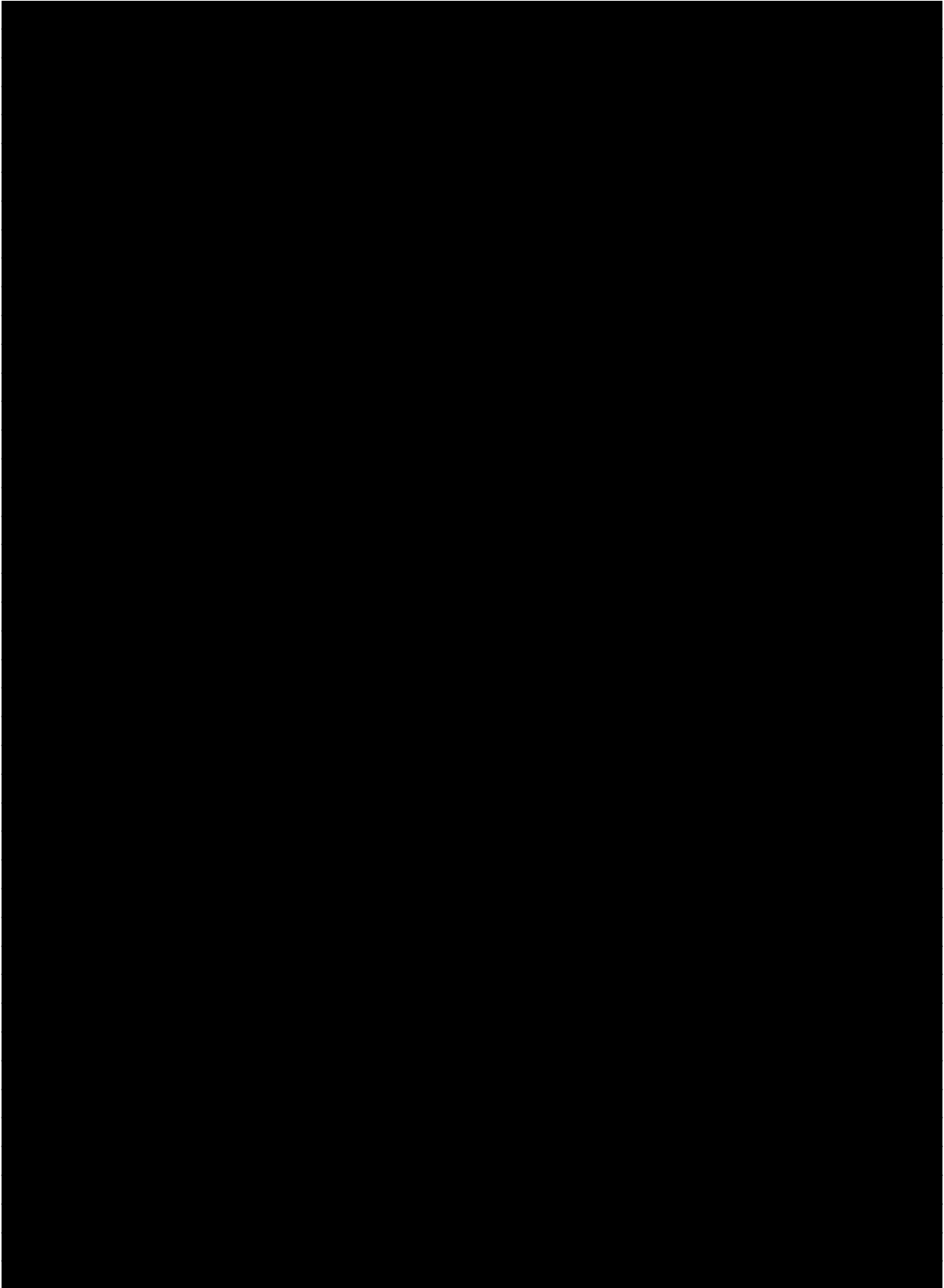
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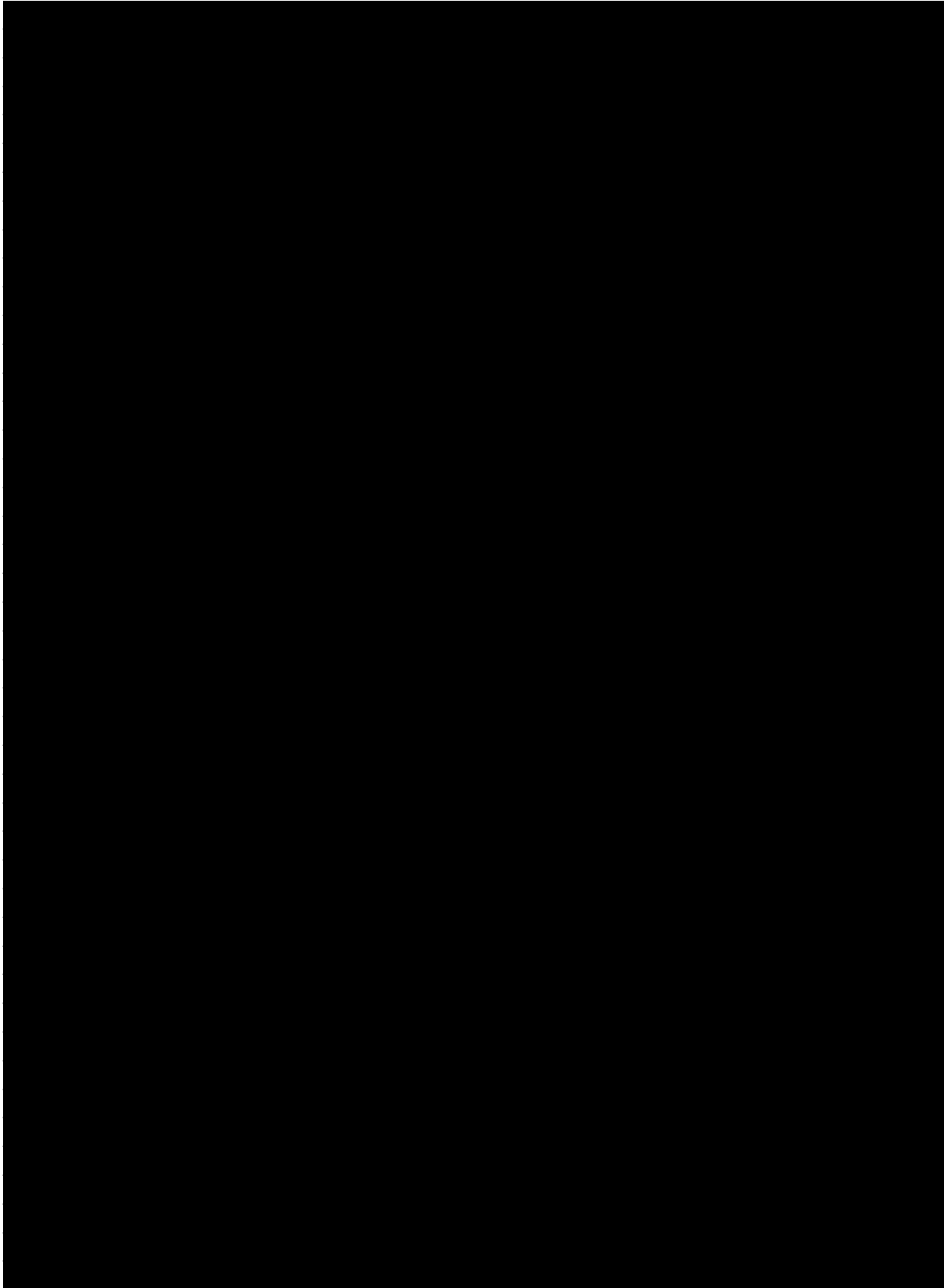


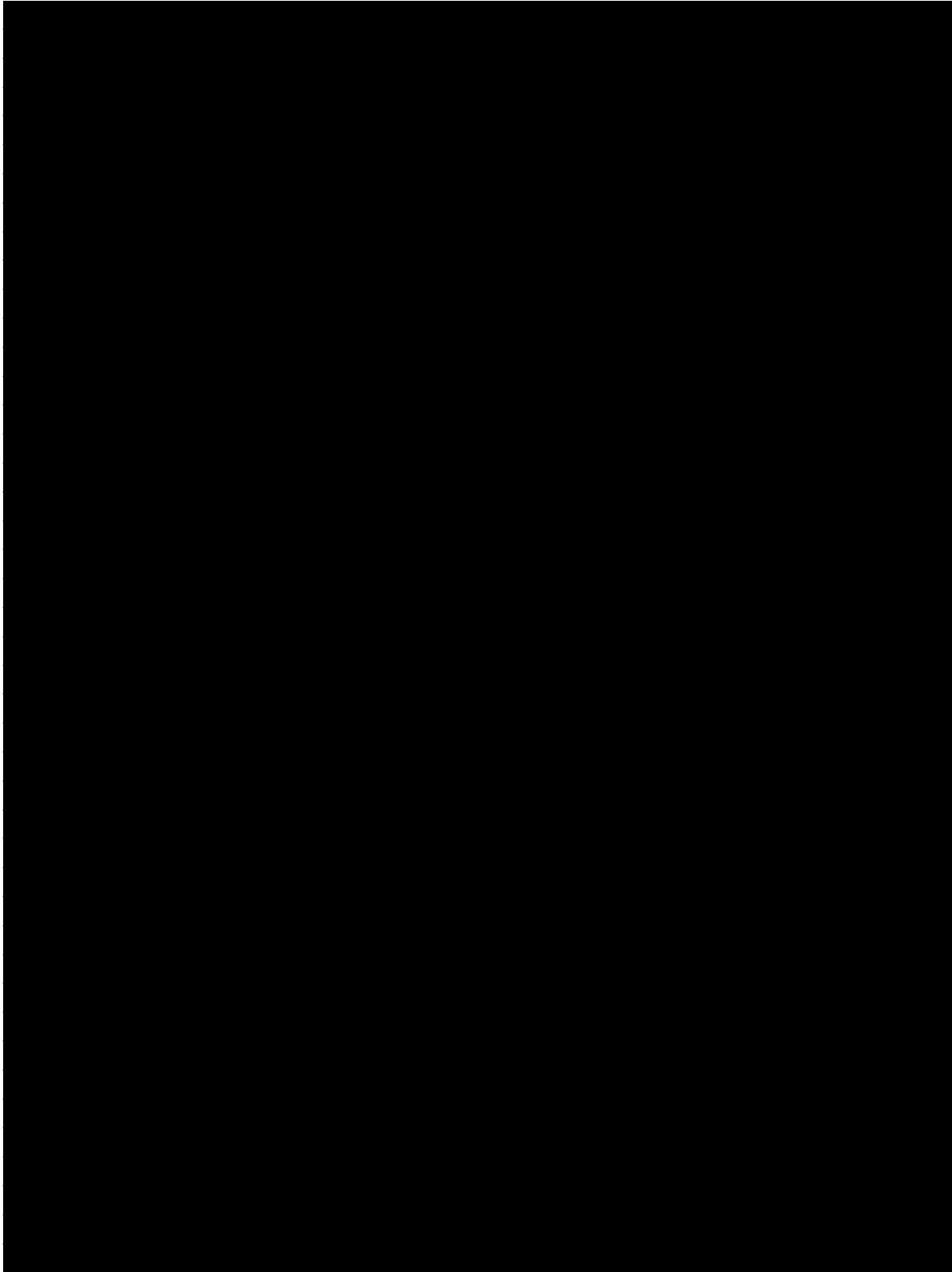
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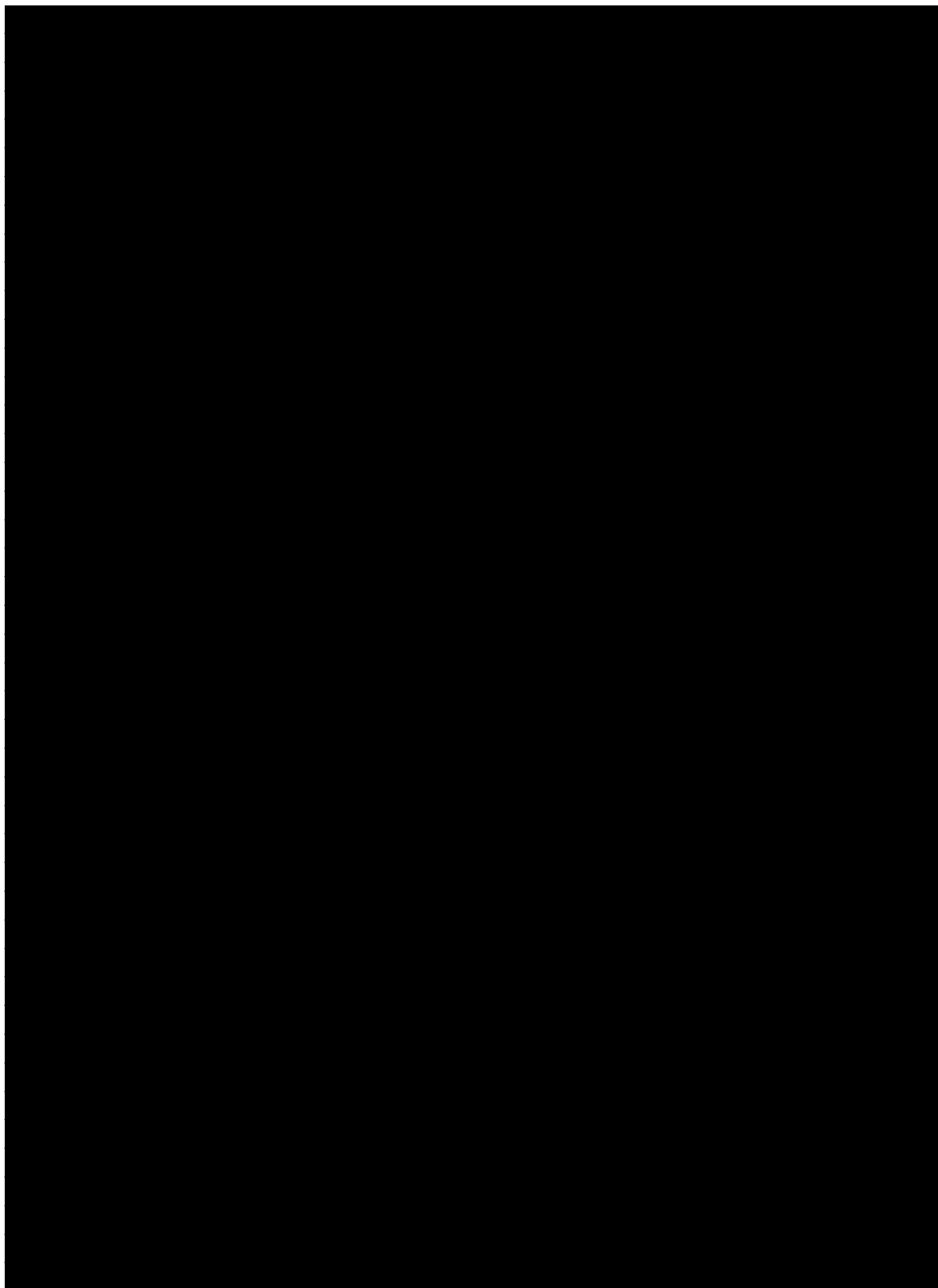


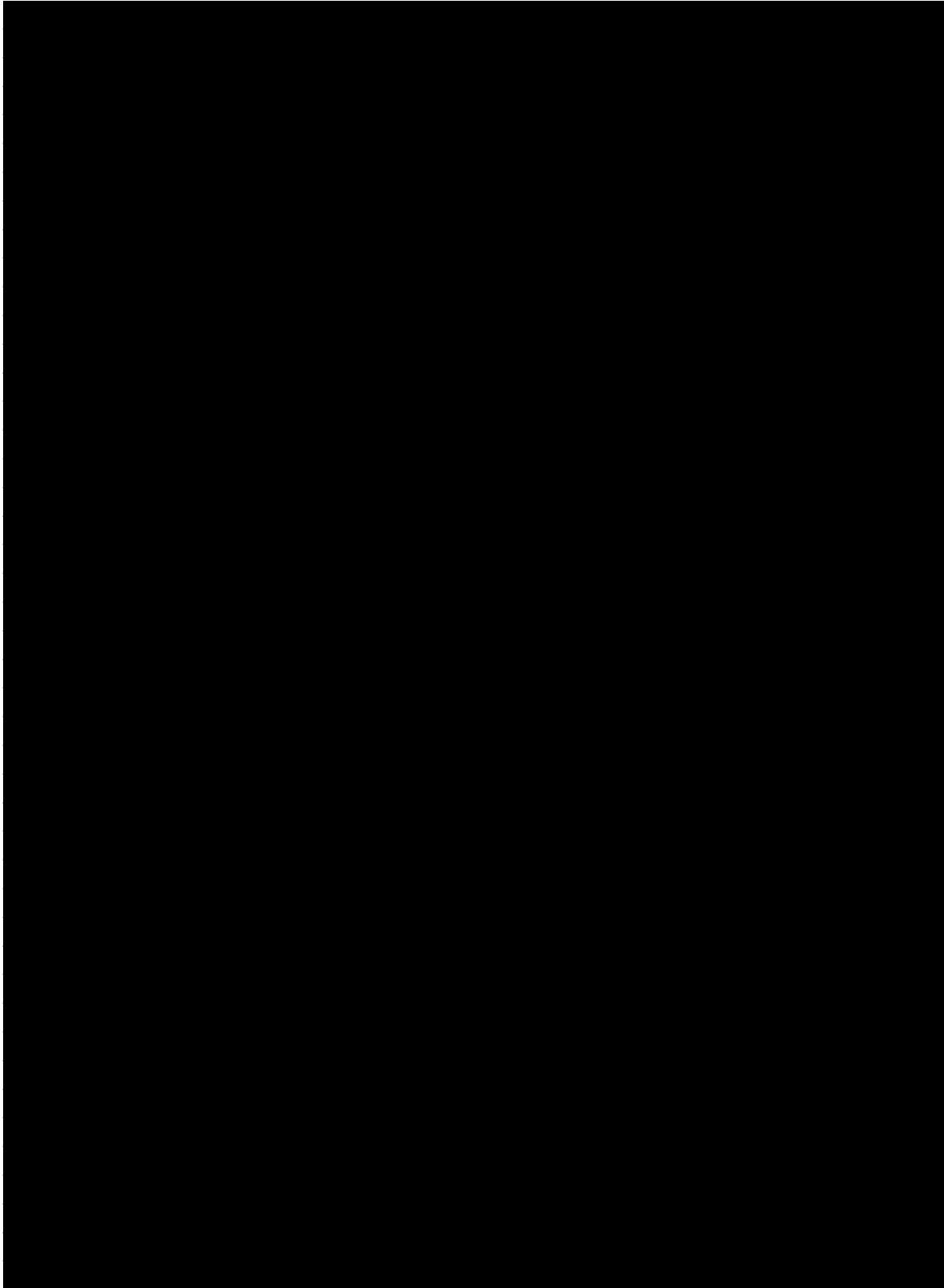
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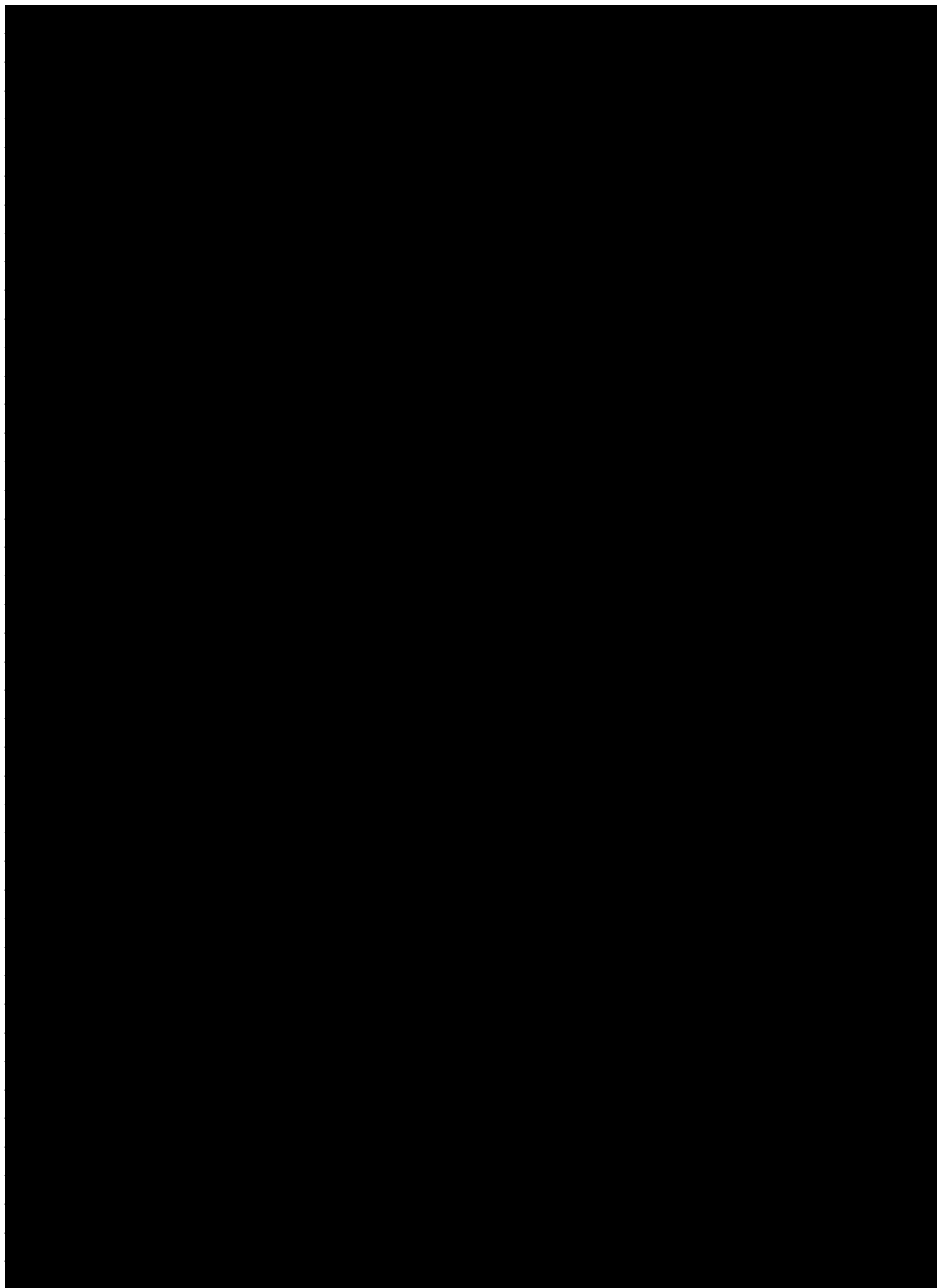
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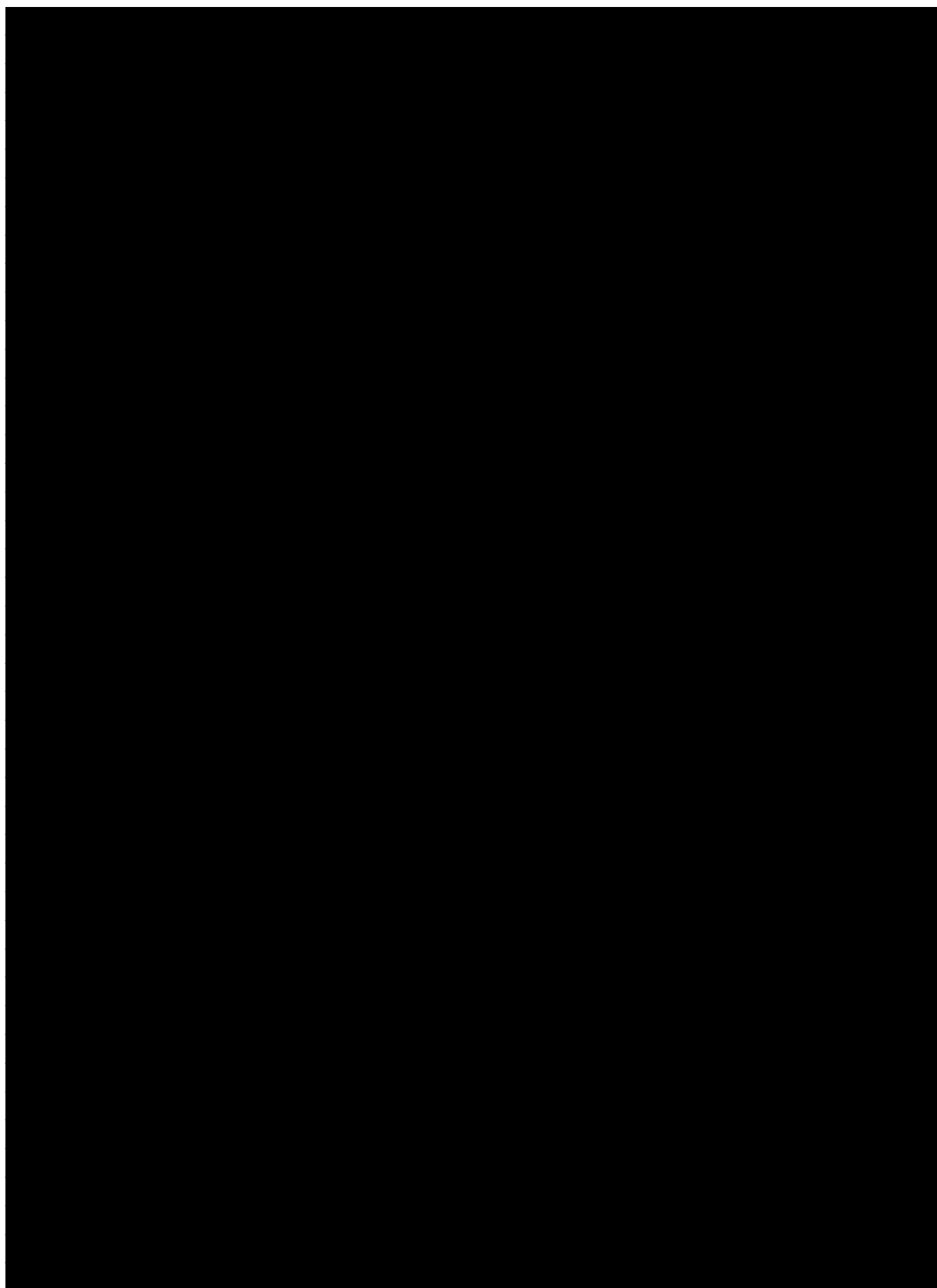
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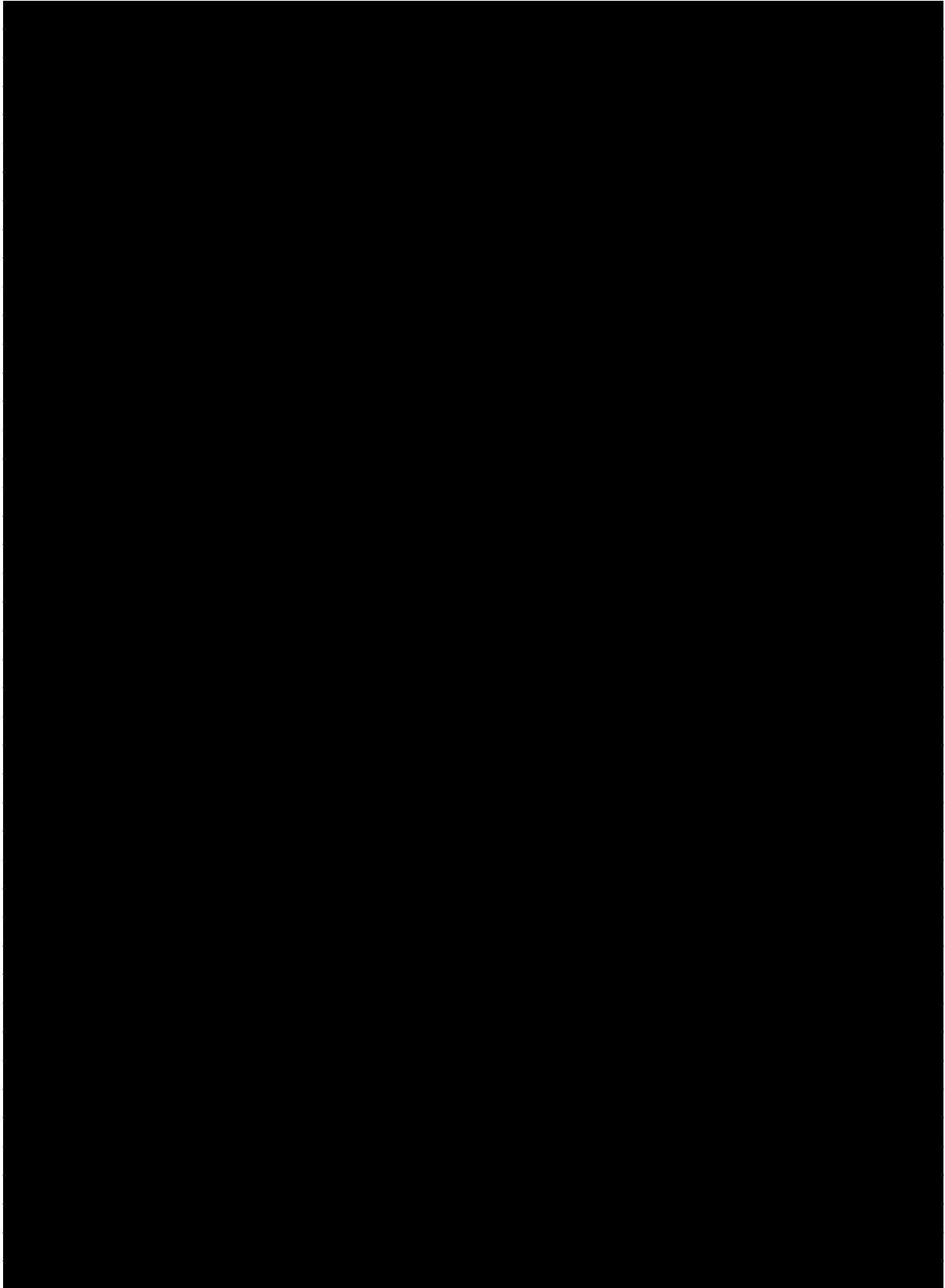
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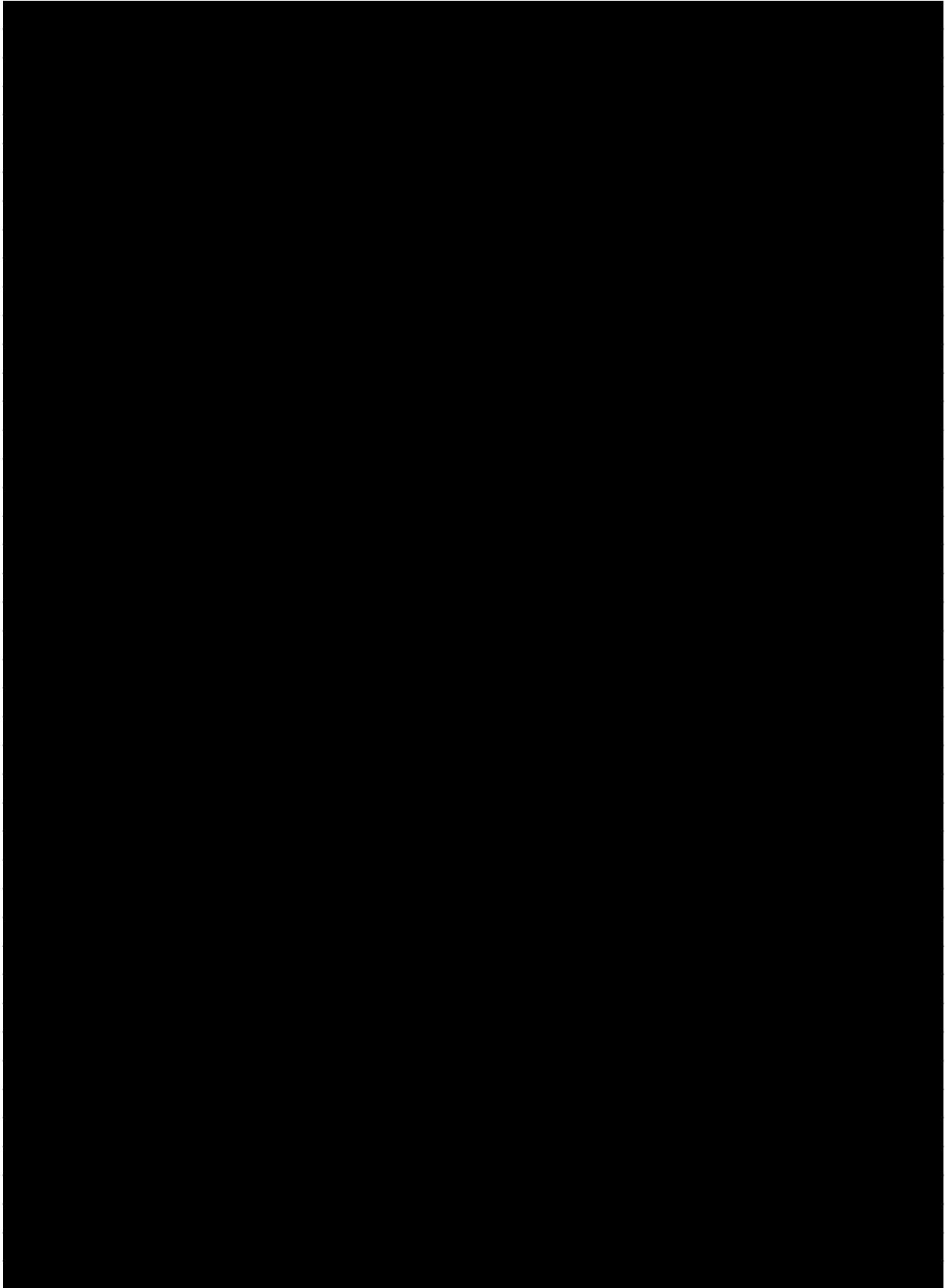








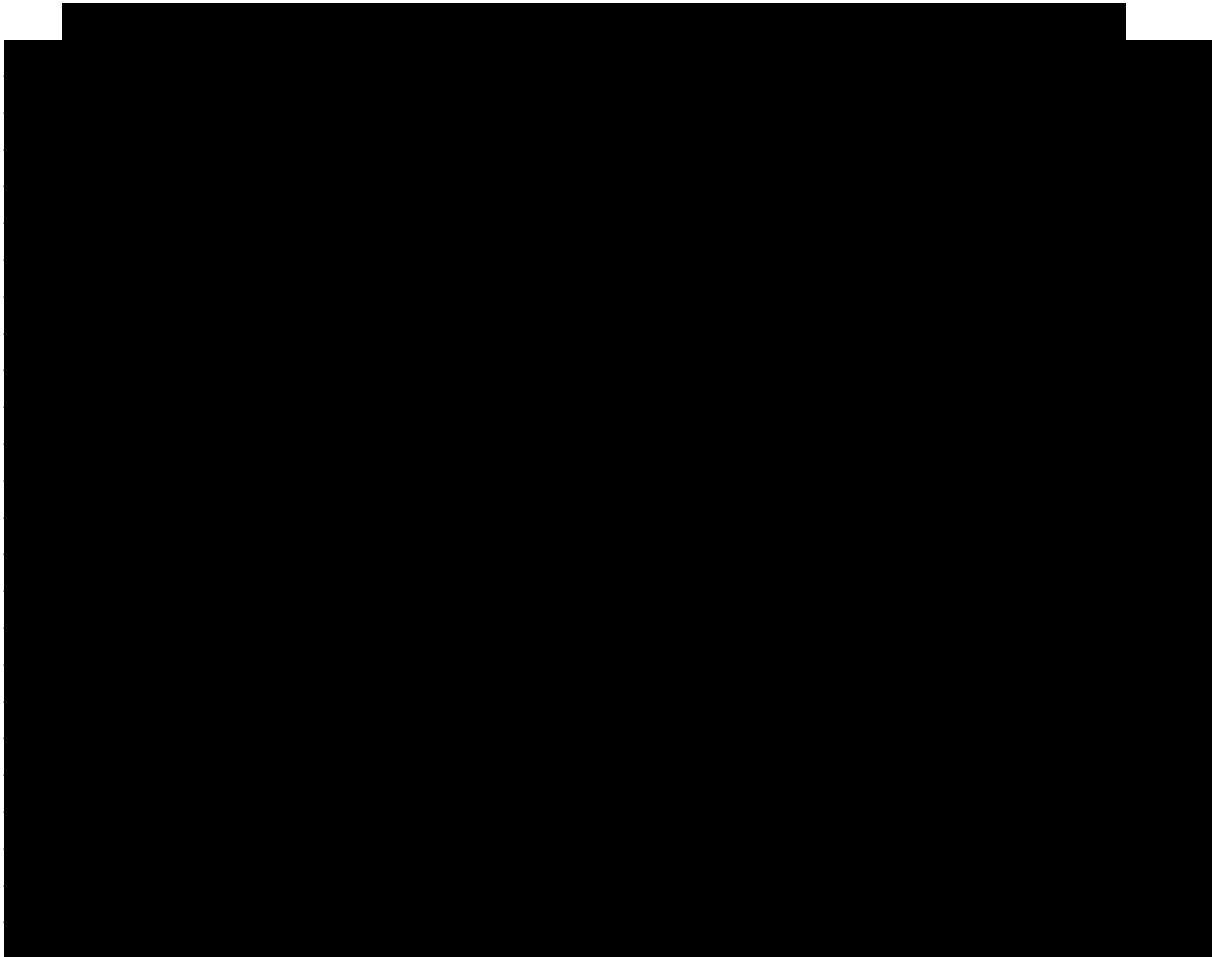


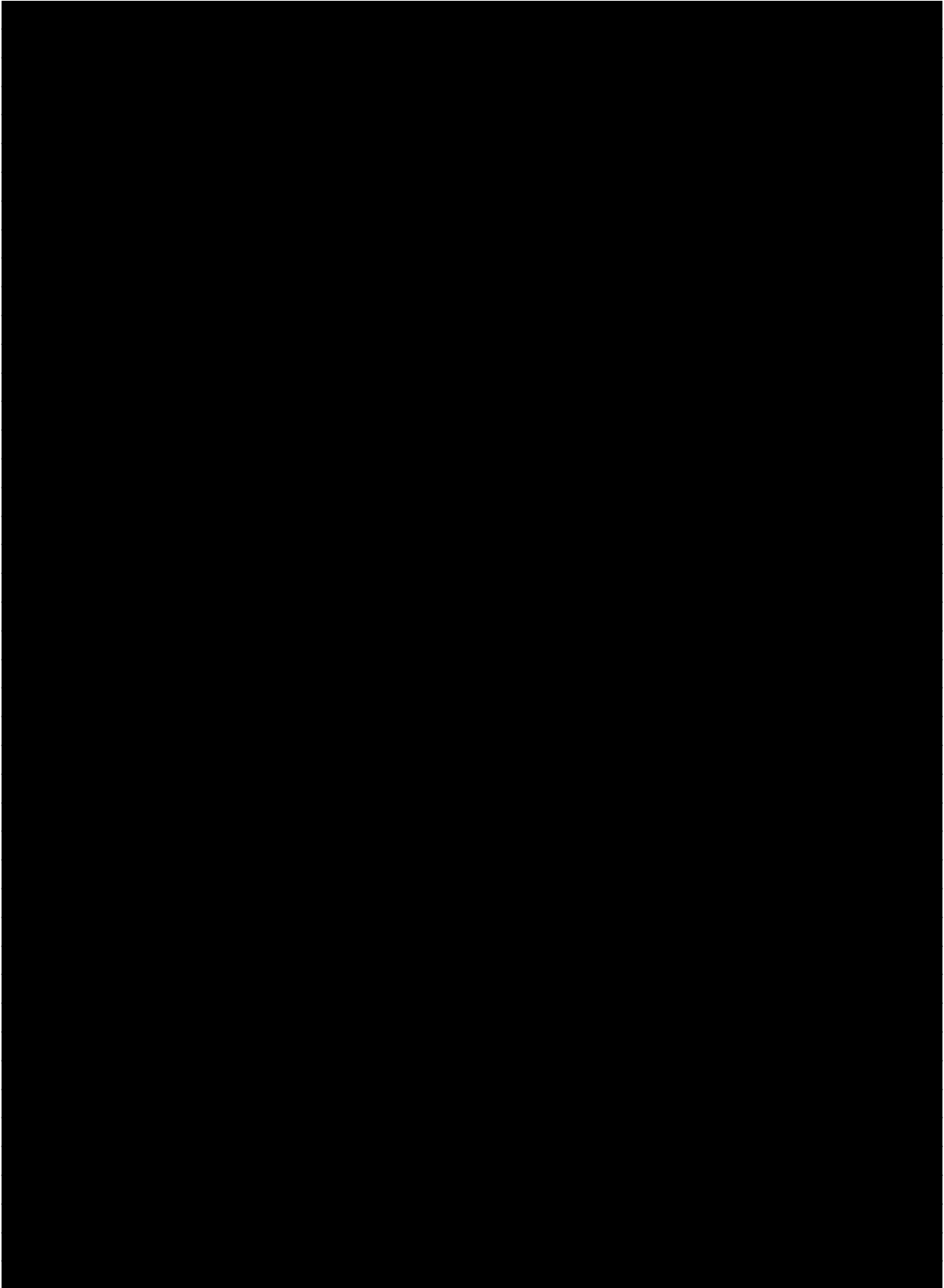


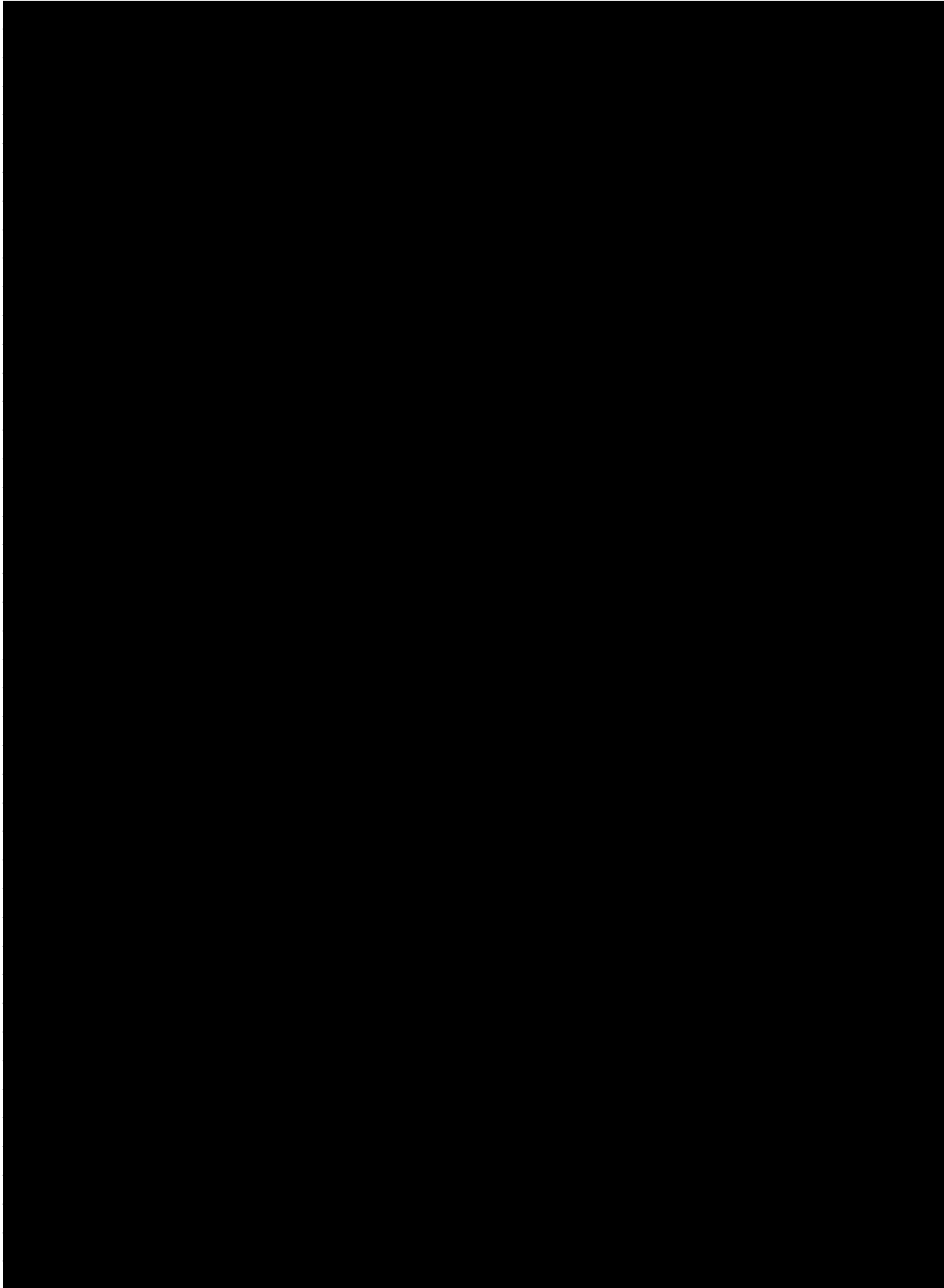
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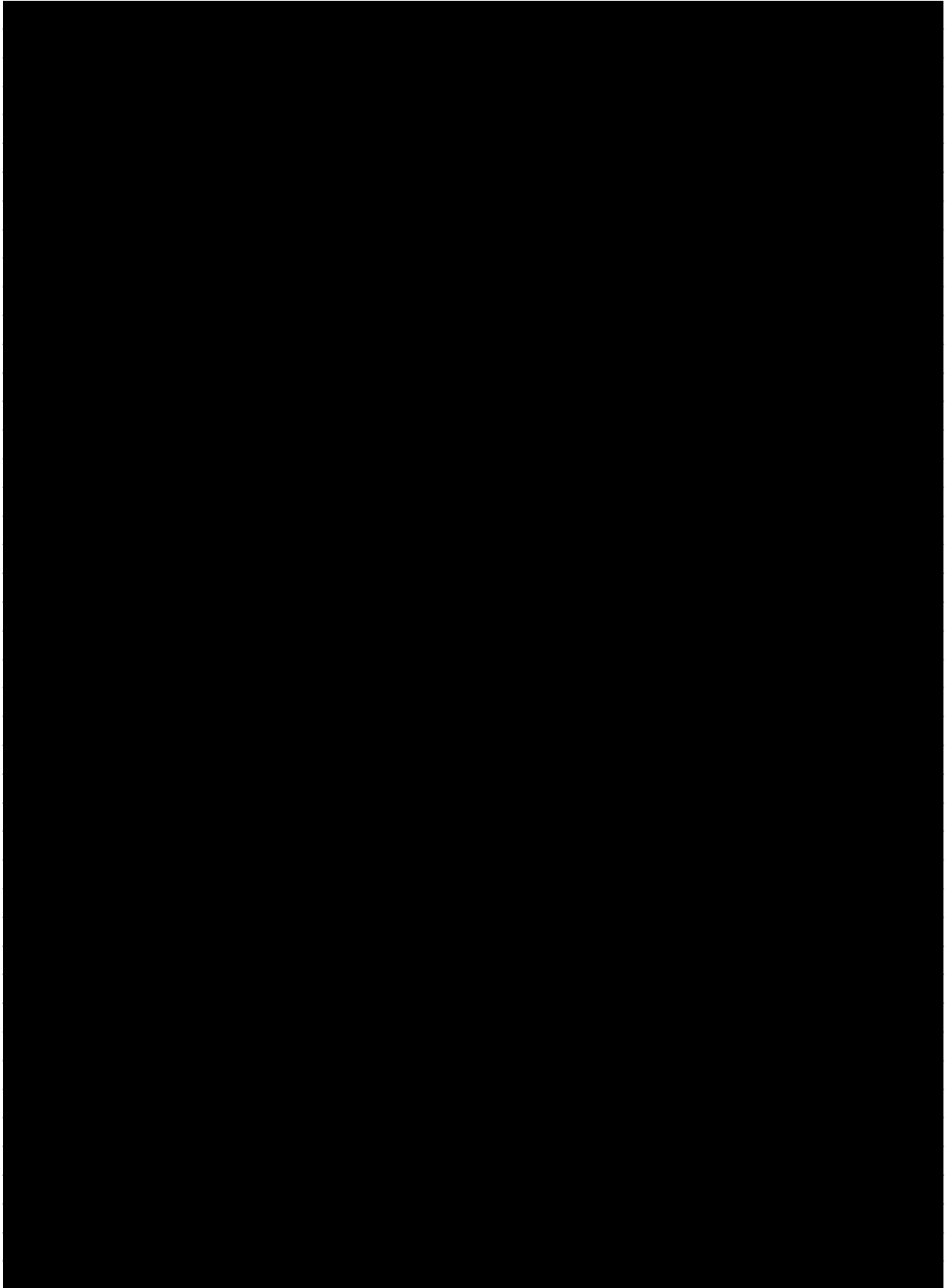


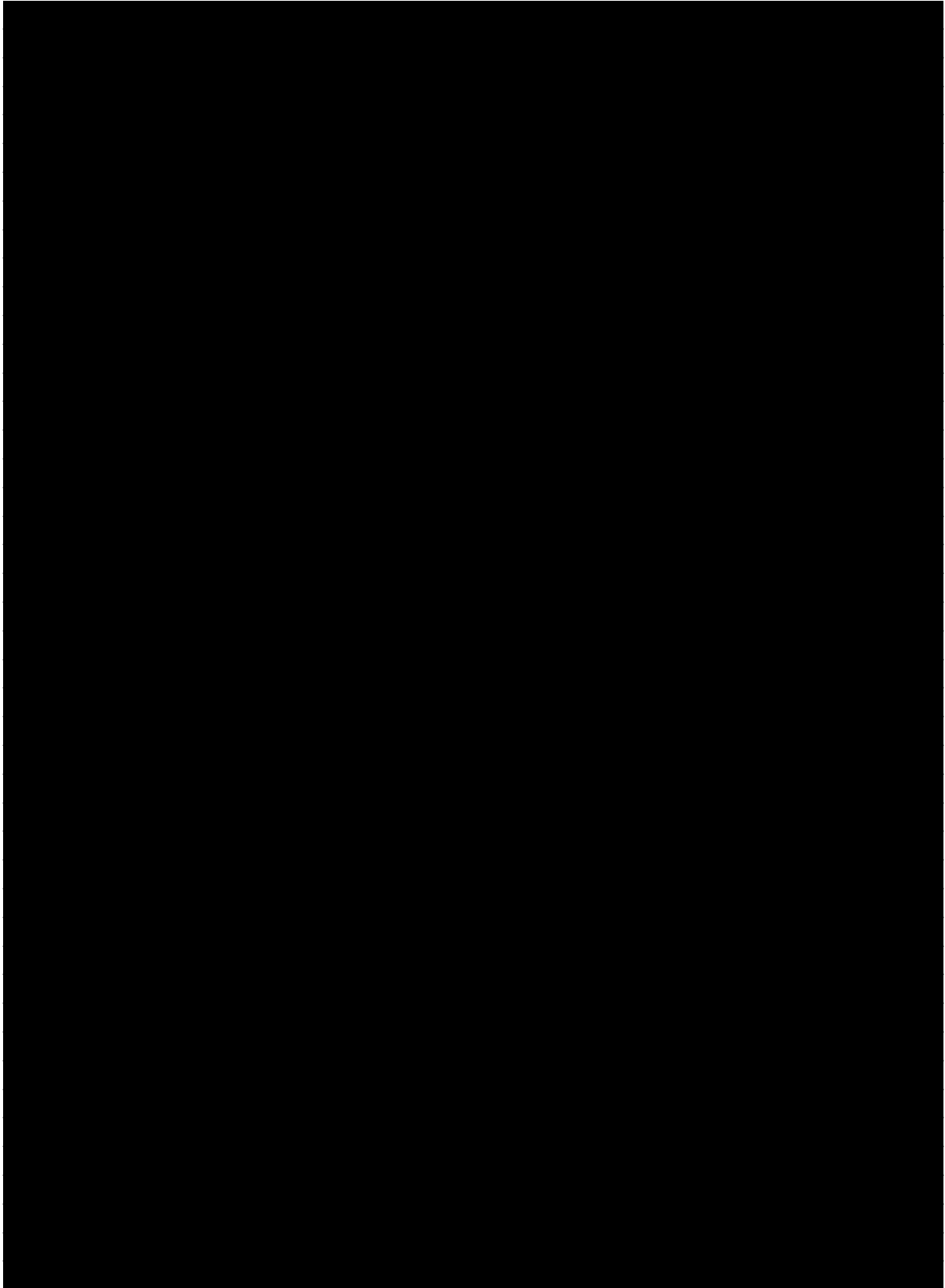
APPLICABLE LAW

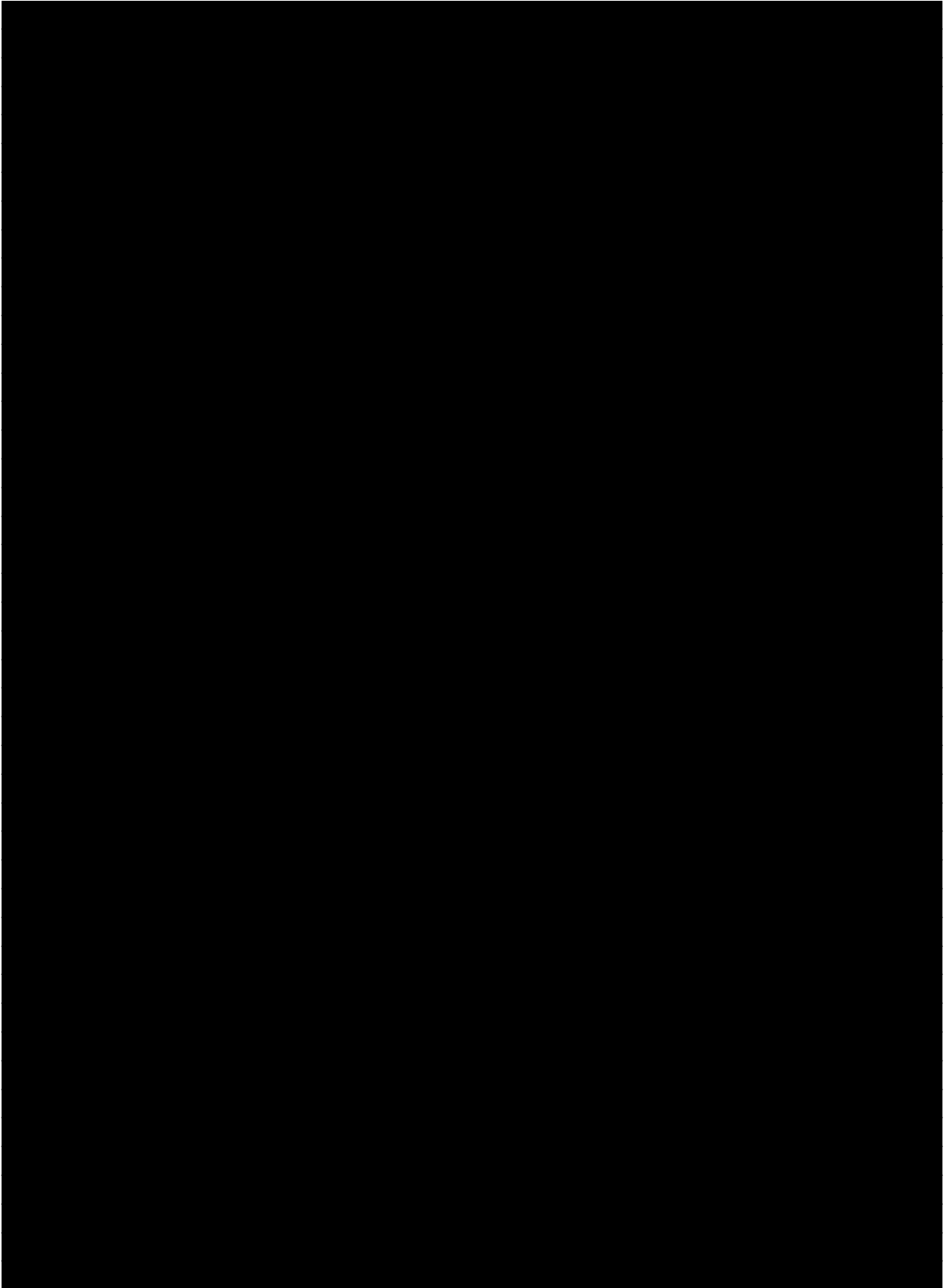


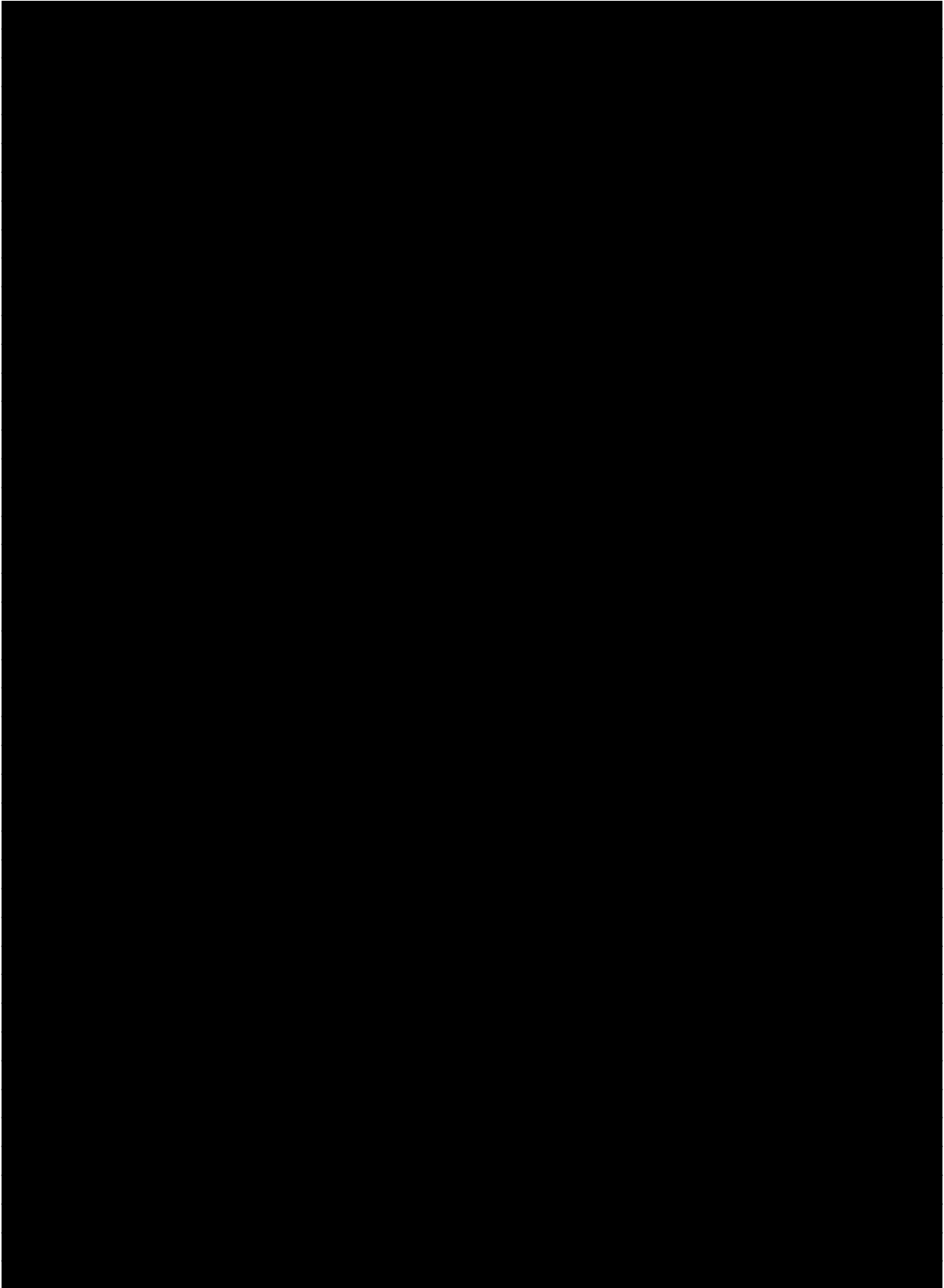






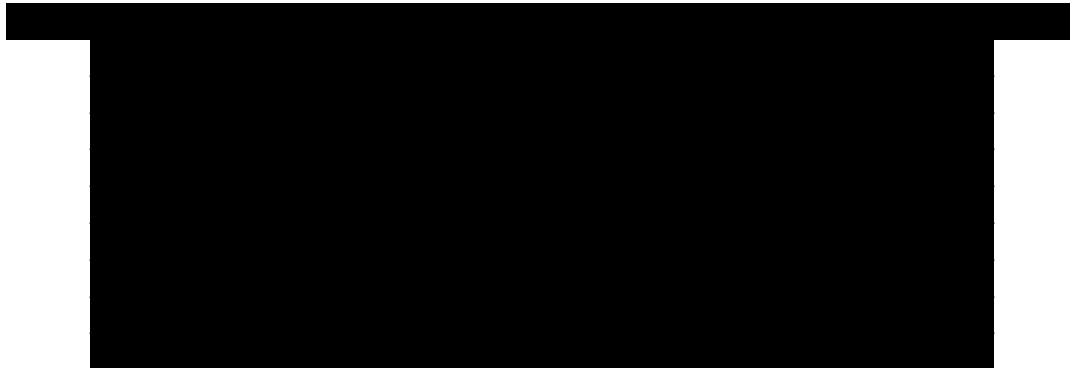




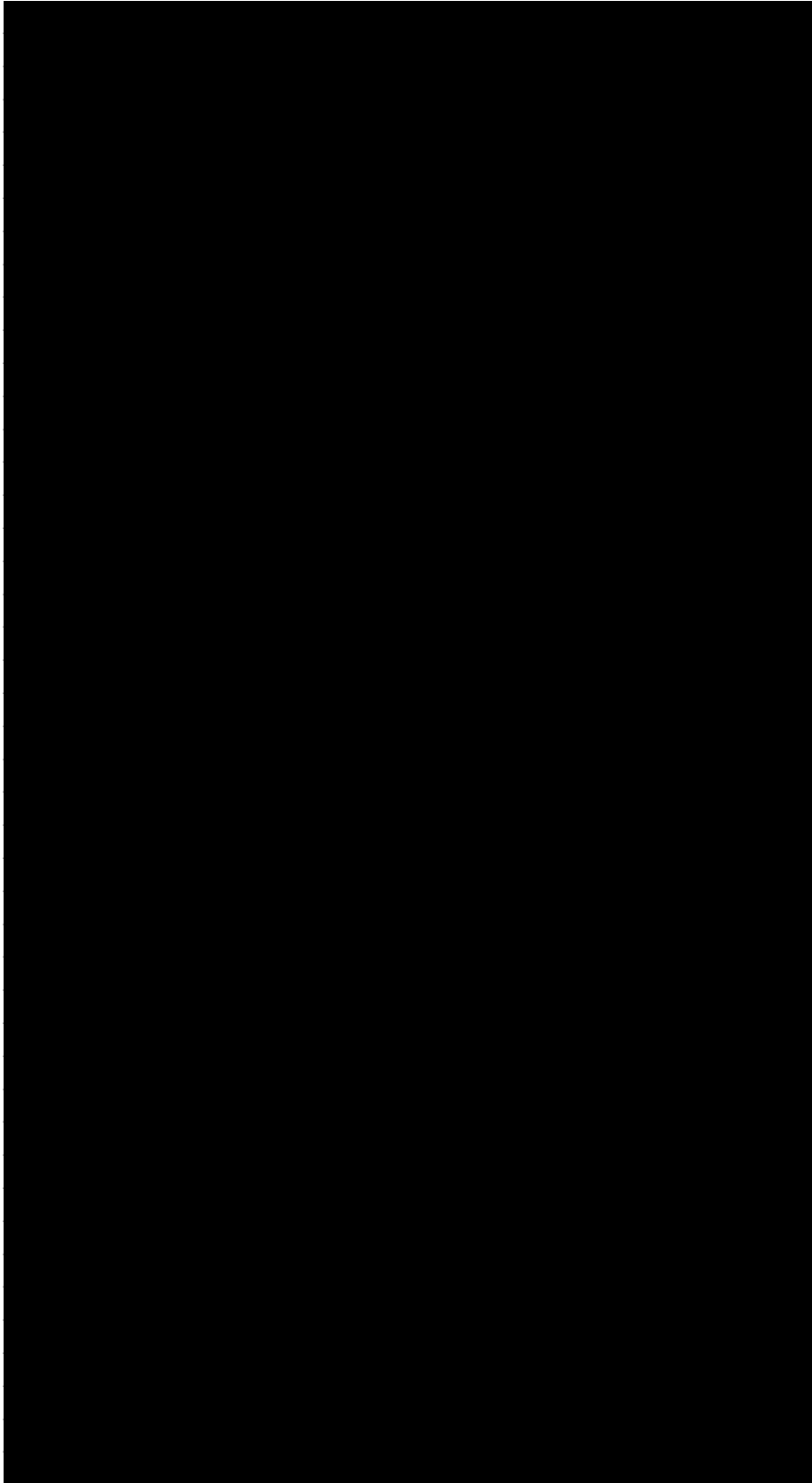


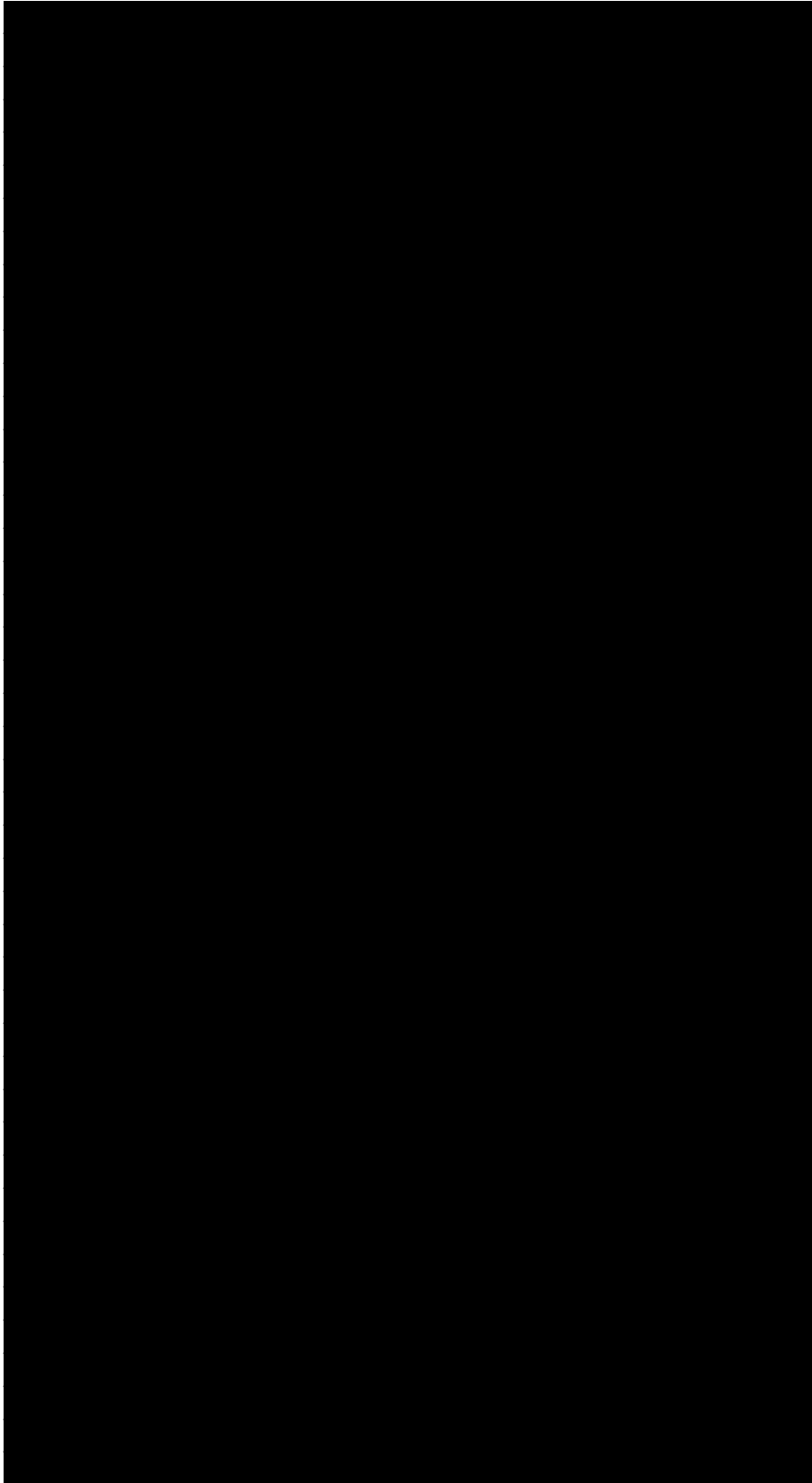


Section 438.210 of 42 CFR Subpart D provides, in pertinent part:

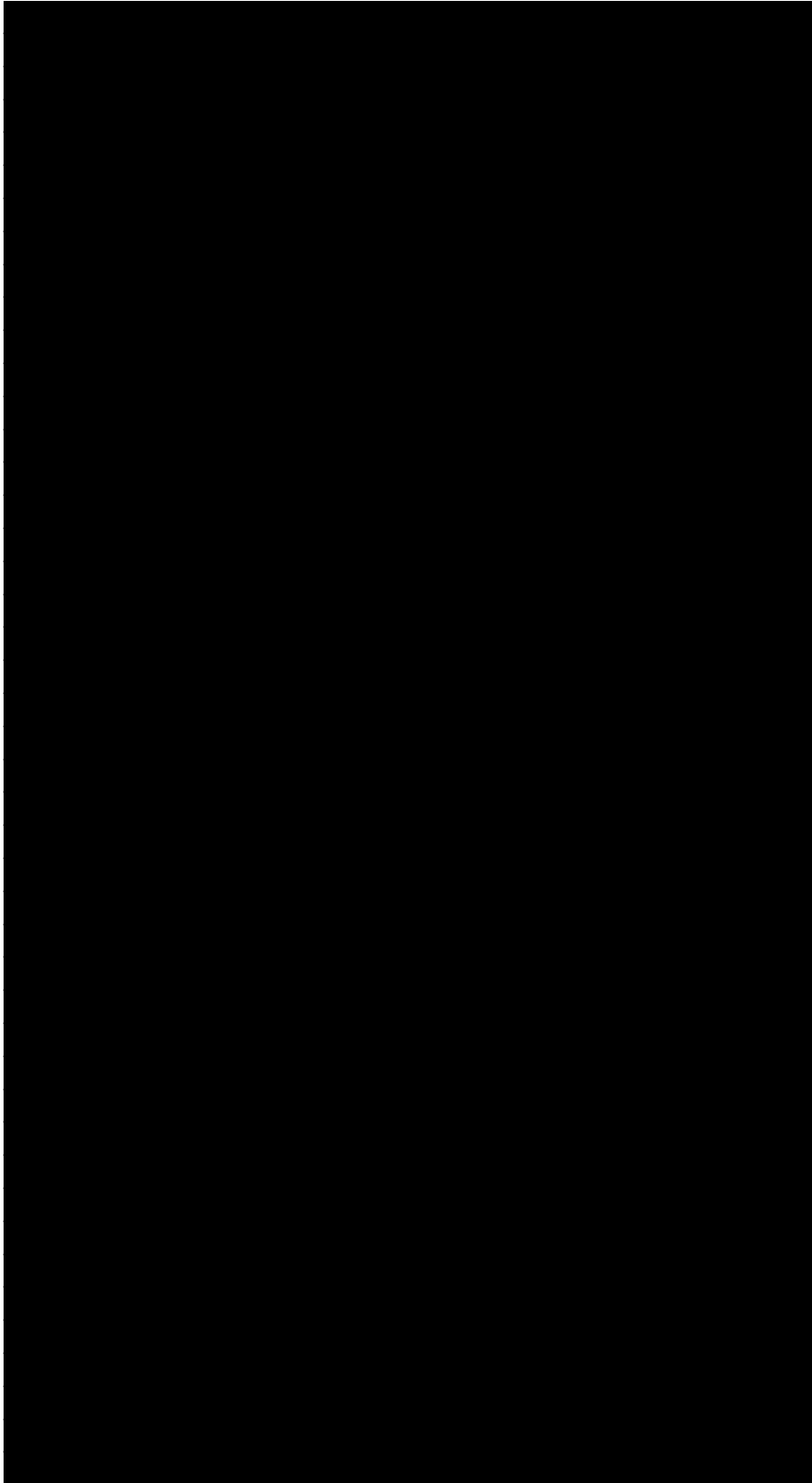


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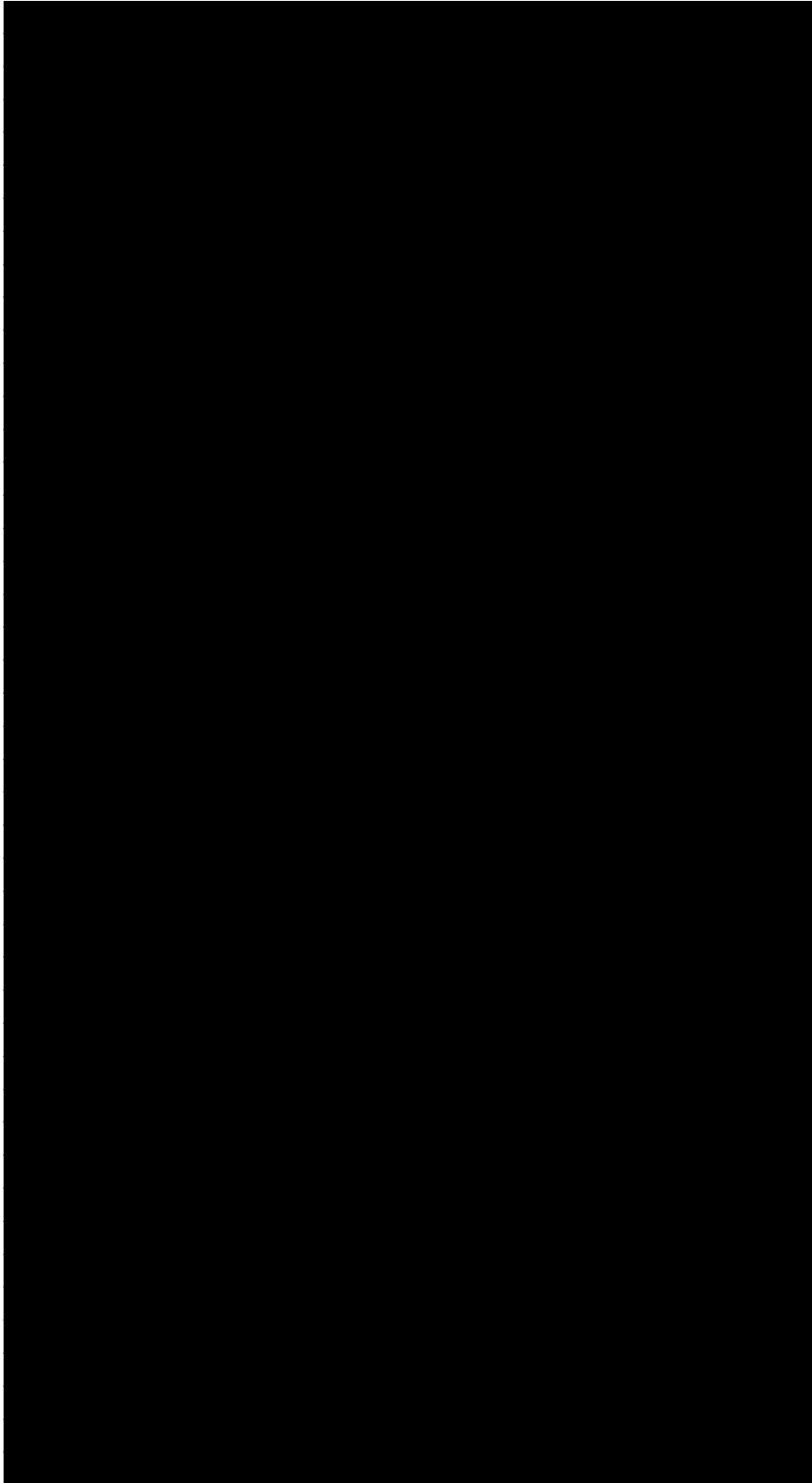




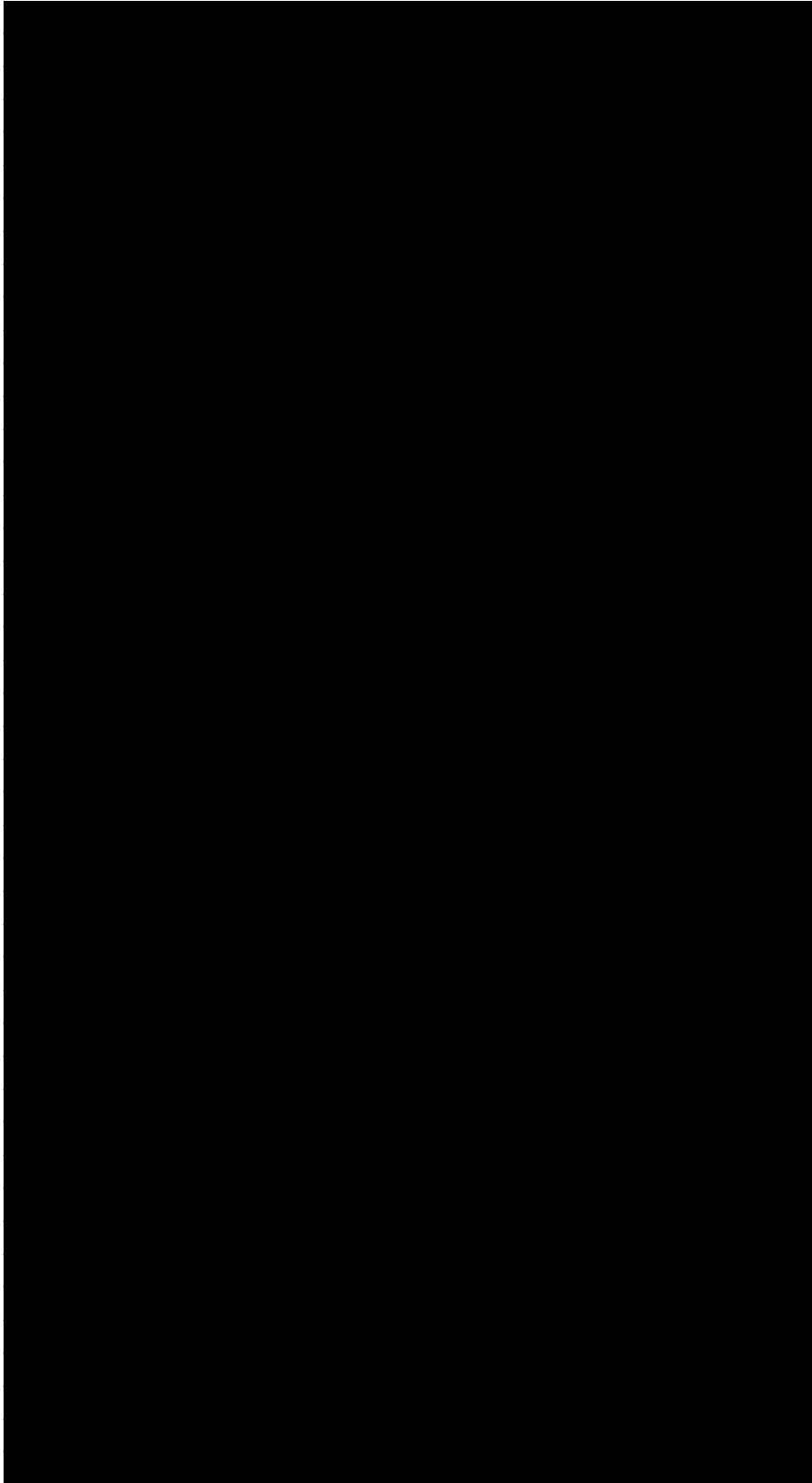
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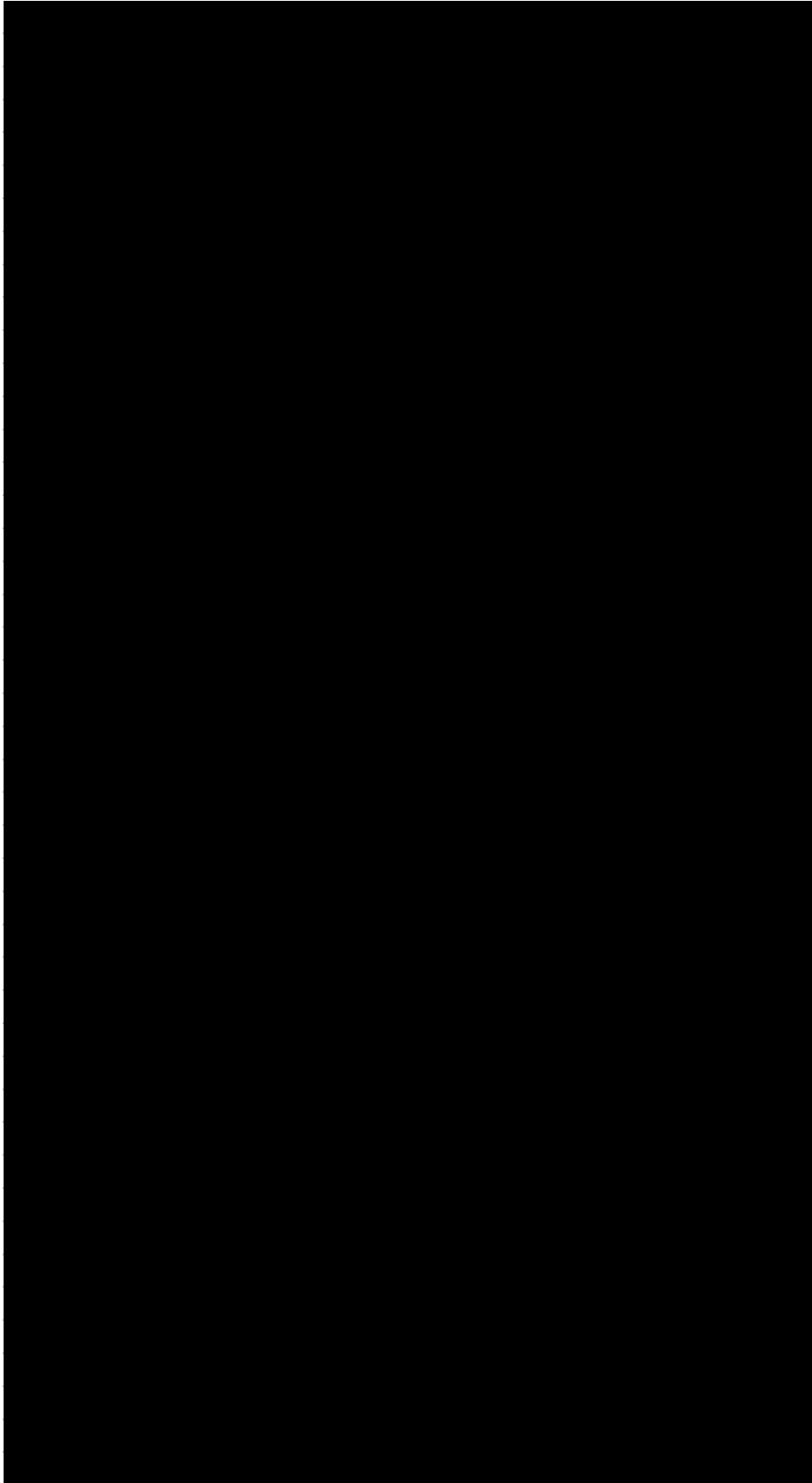
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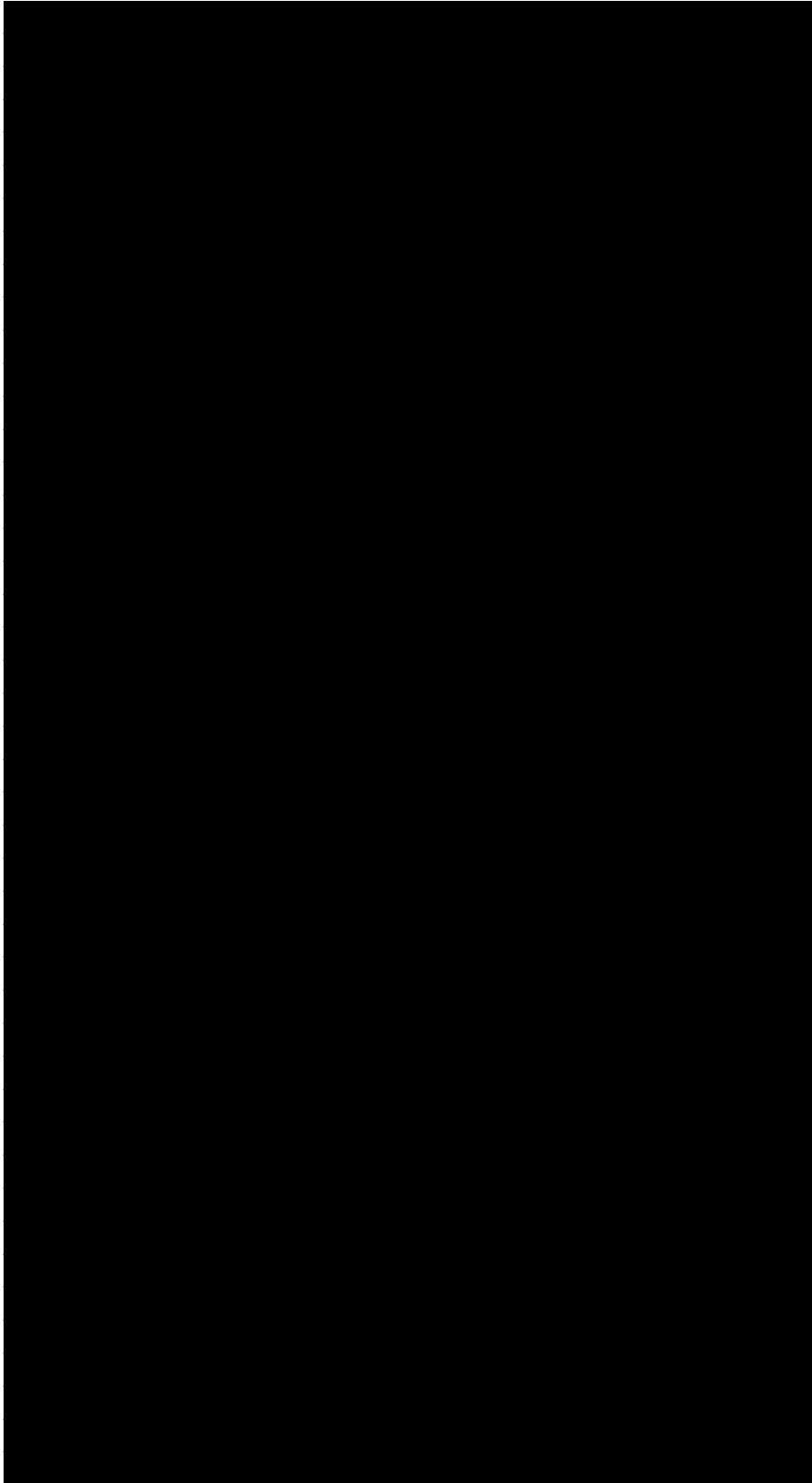
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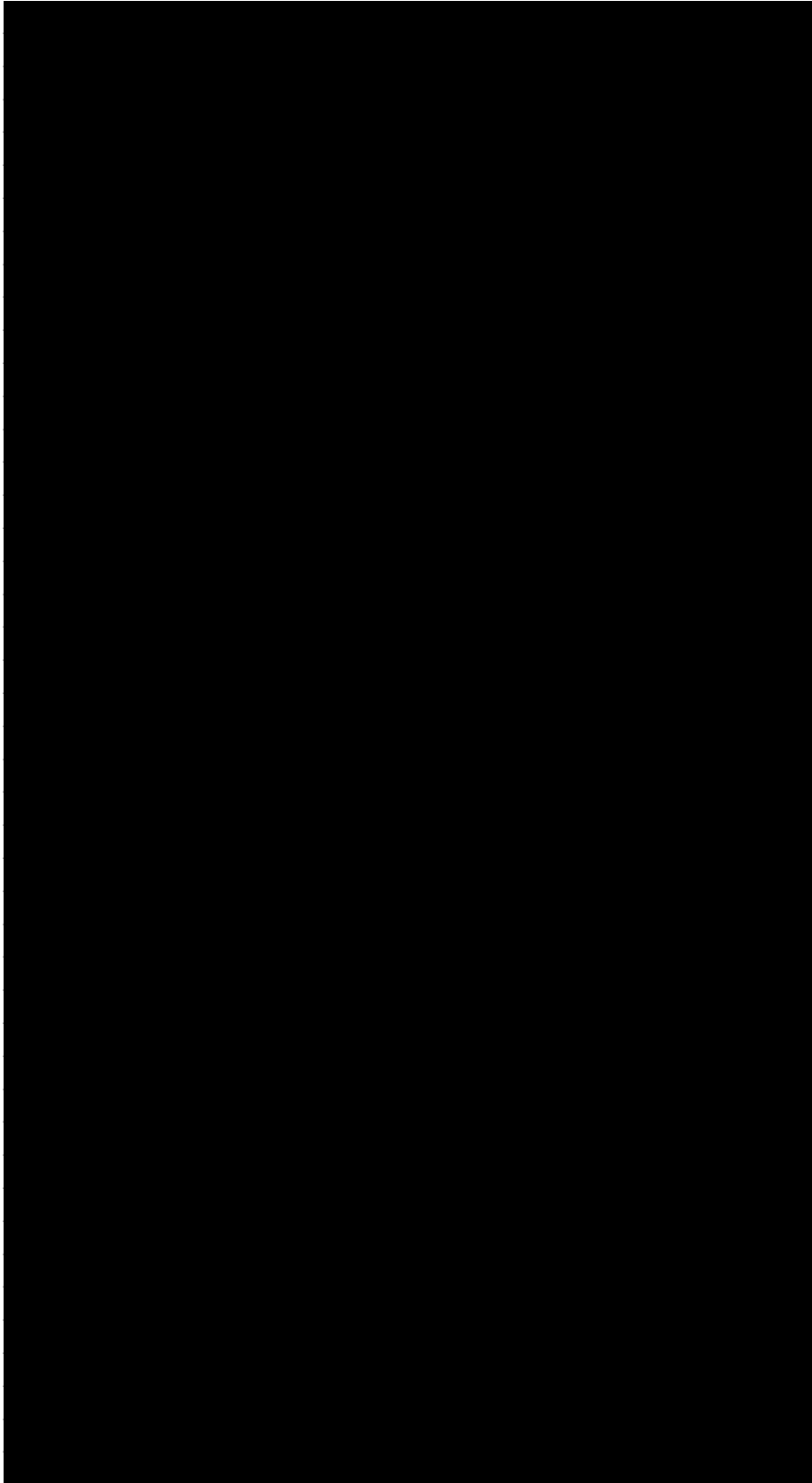
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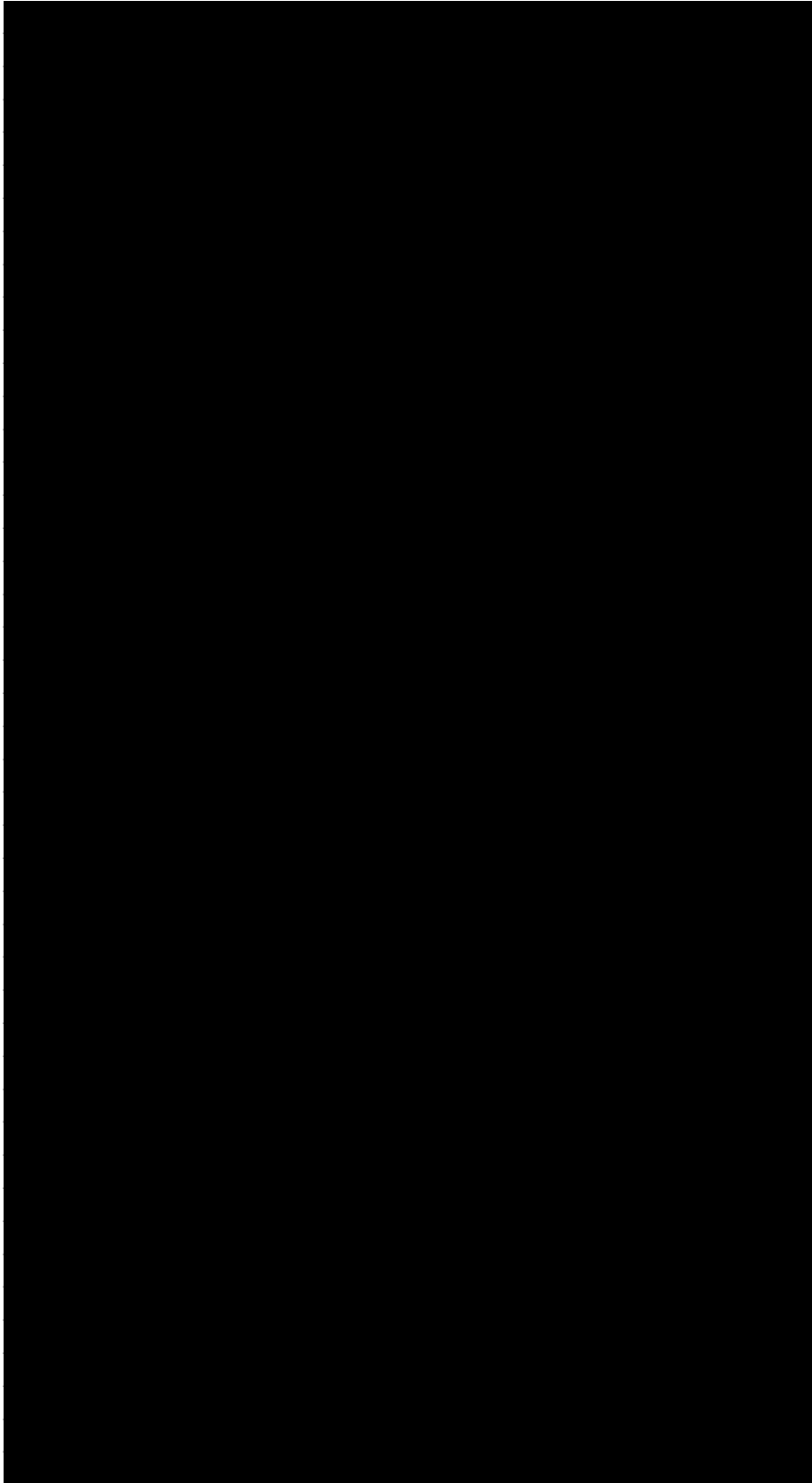
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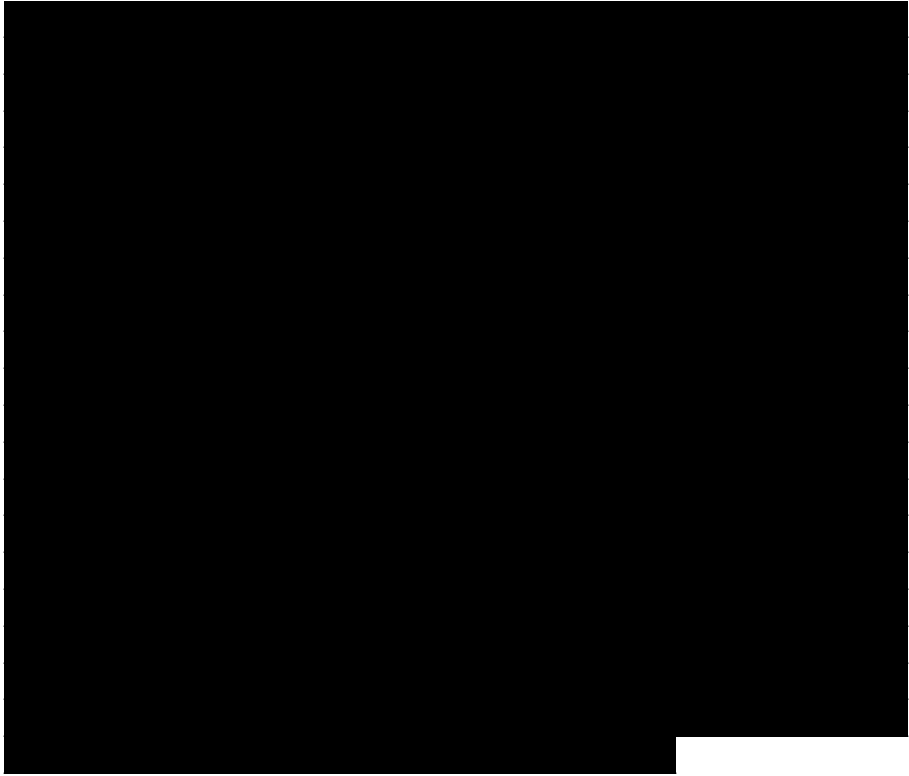
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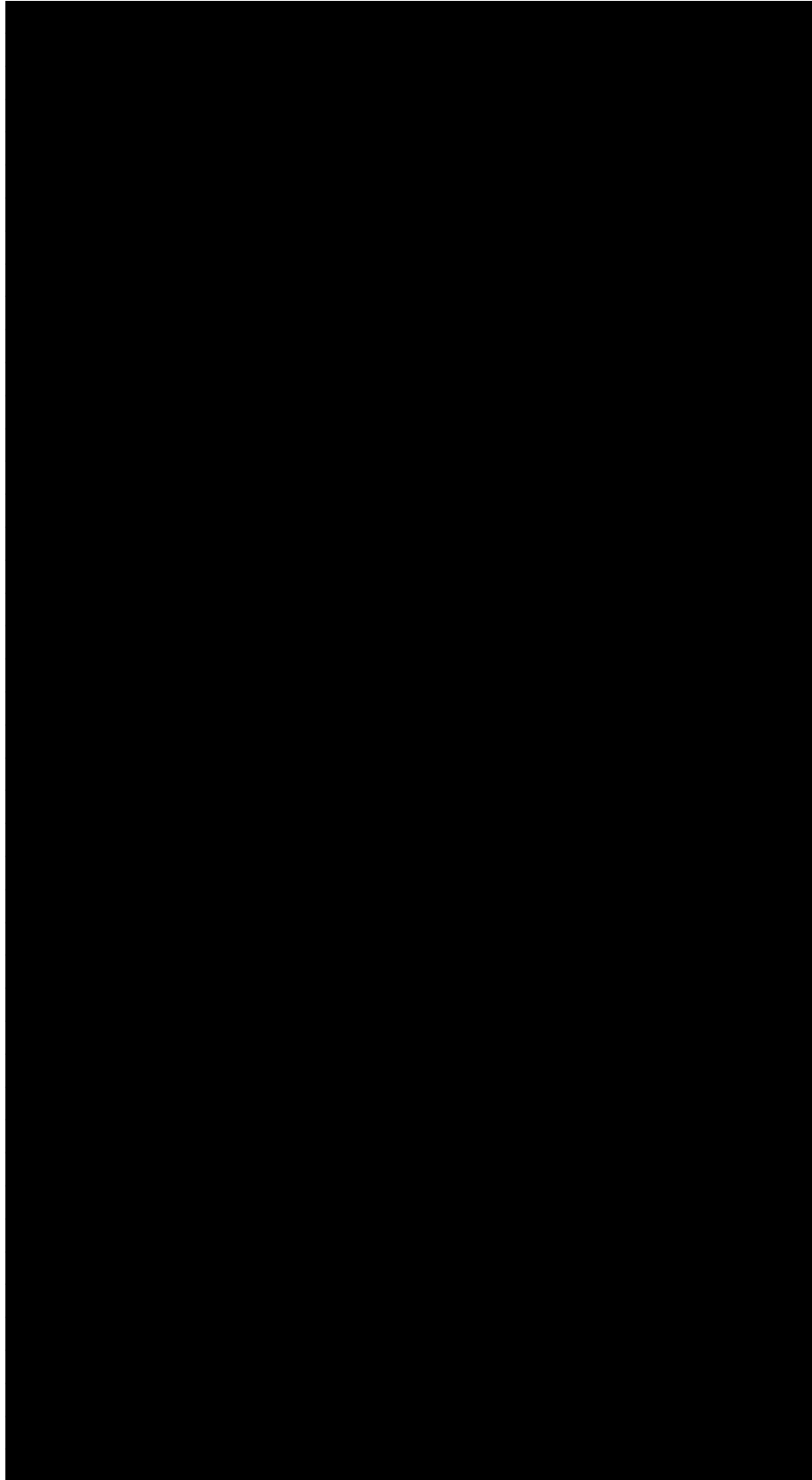
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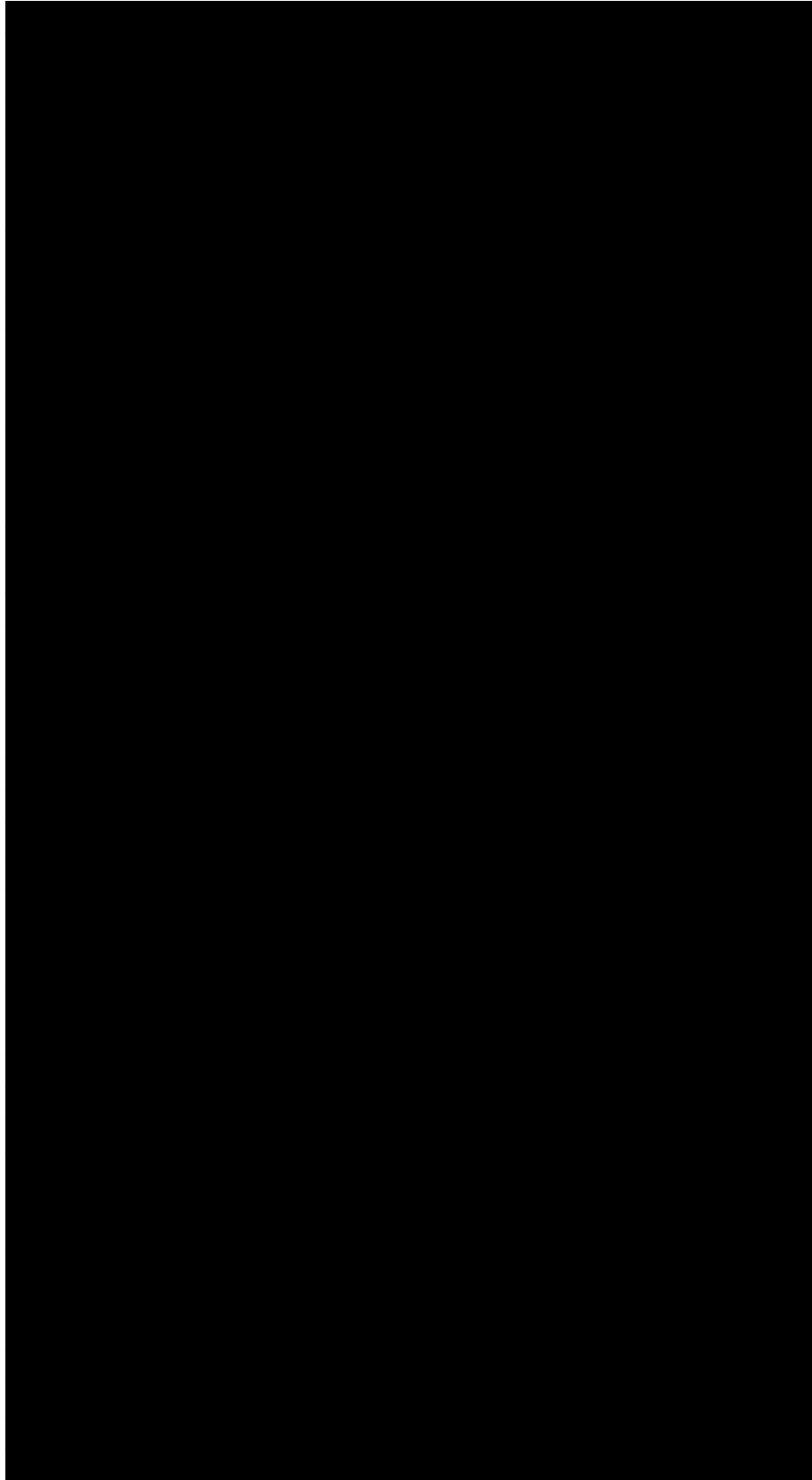


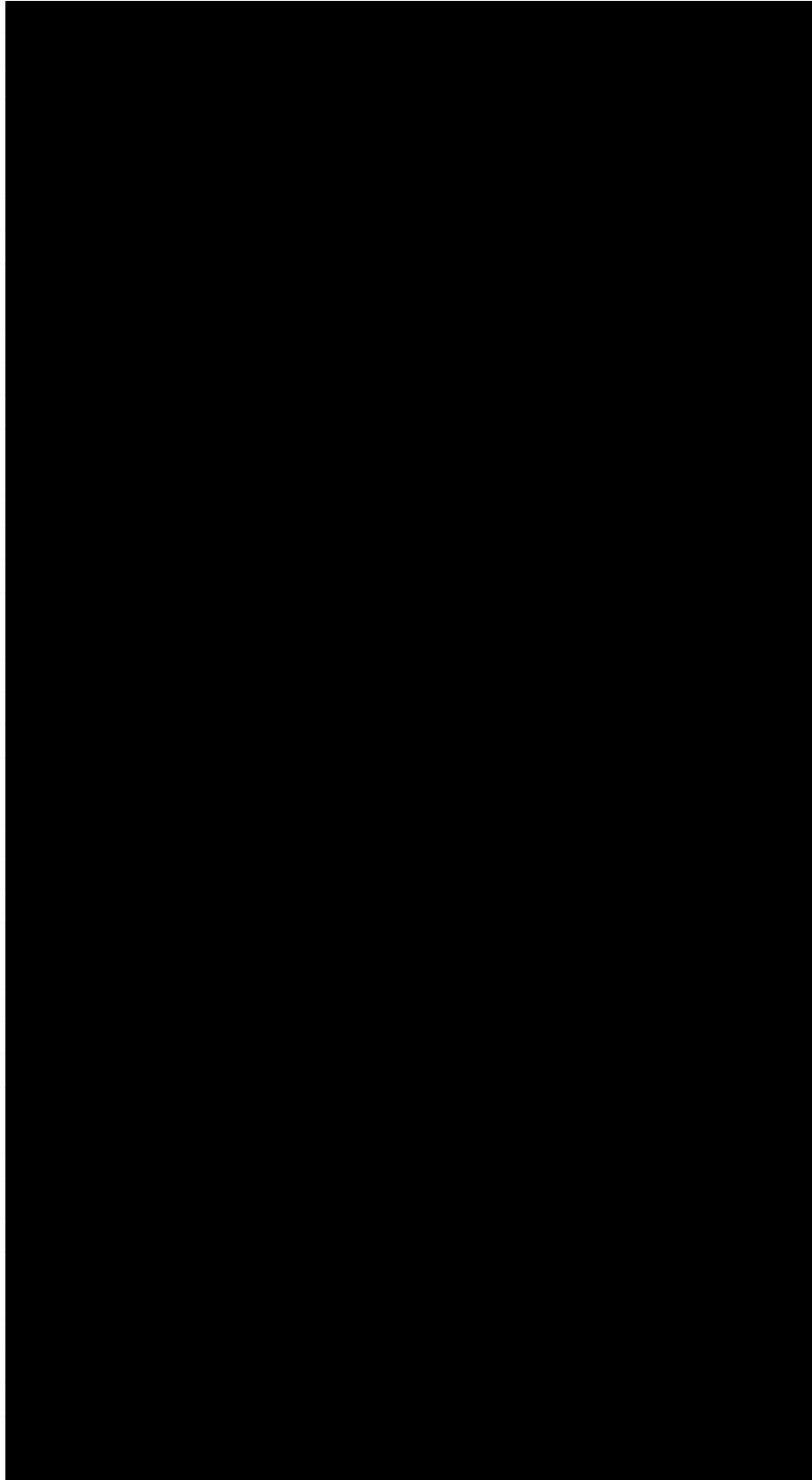
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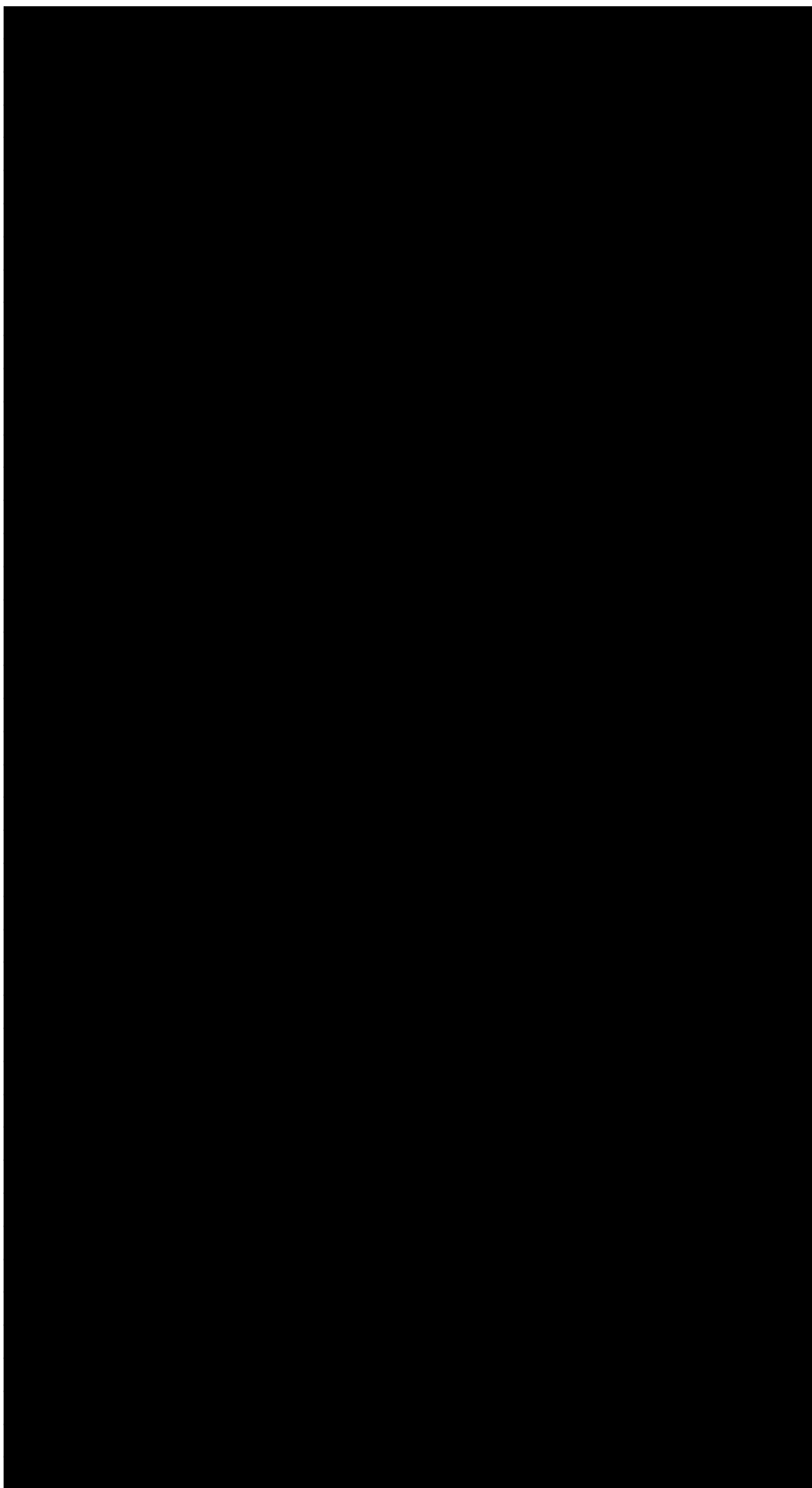


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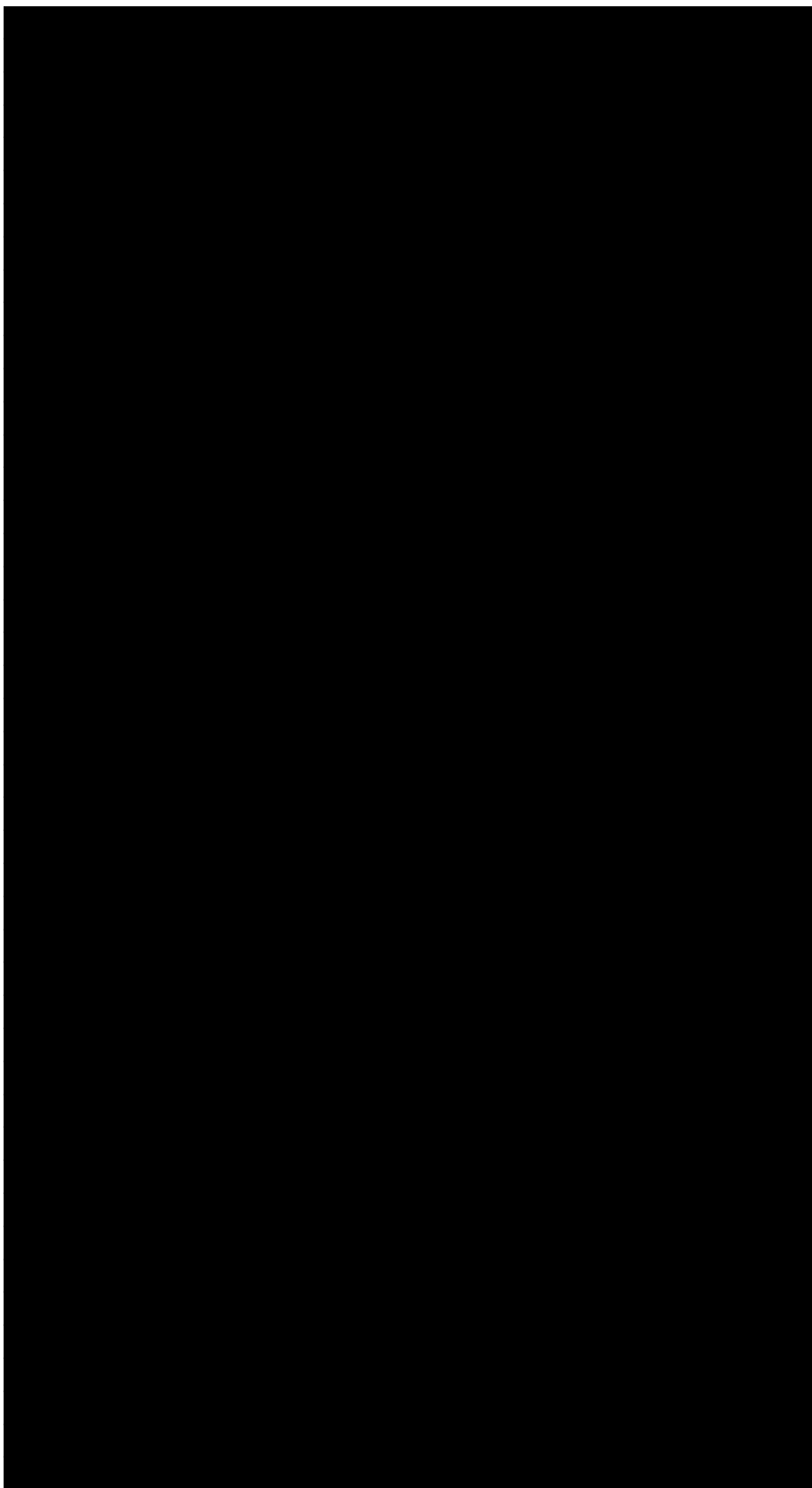








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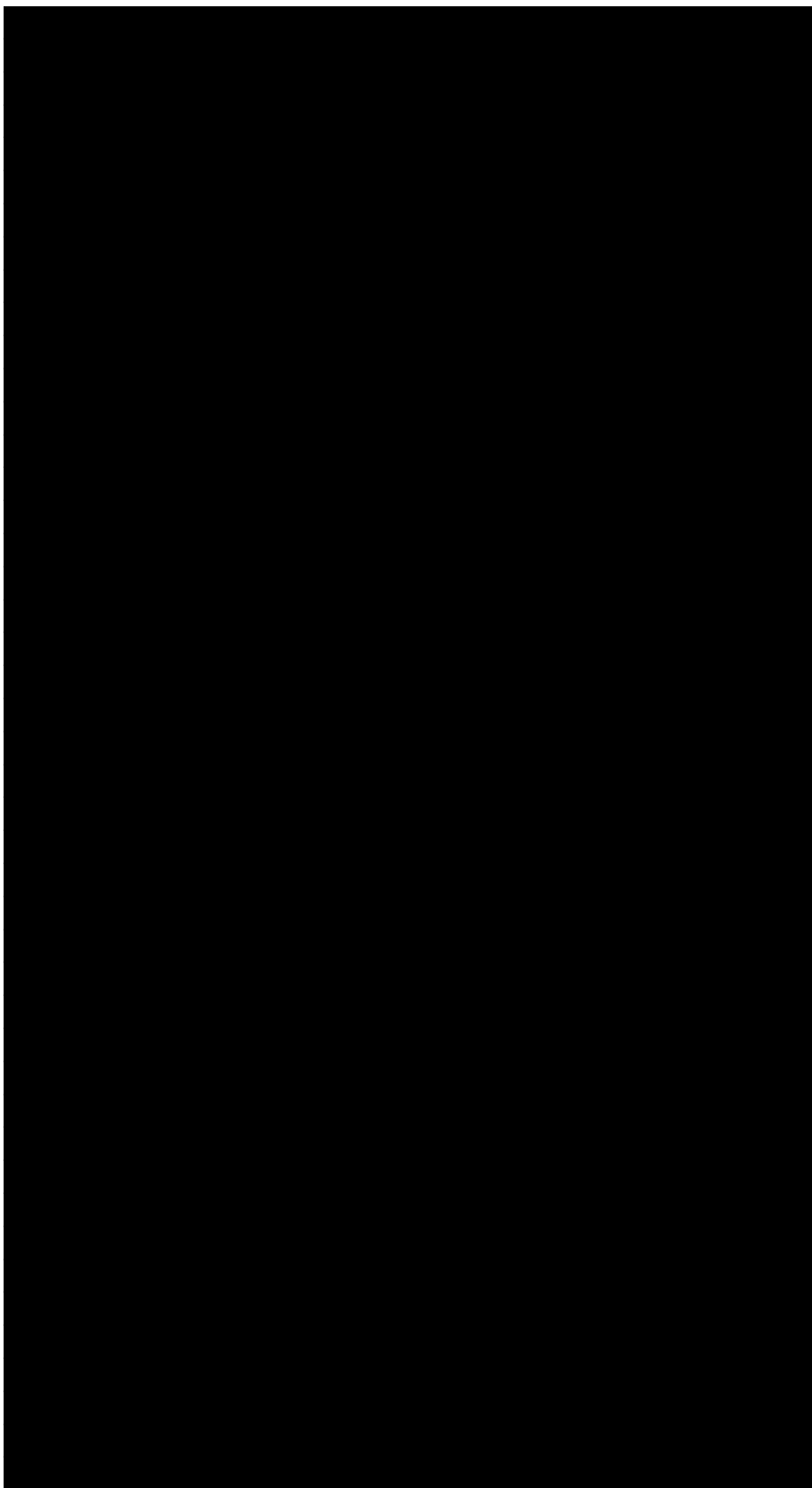




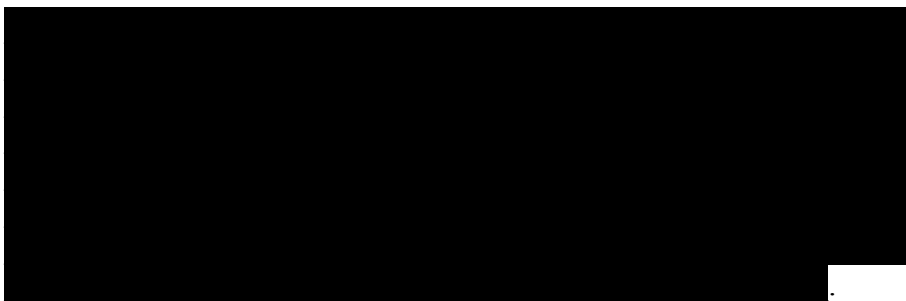
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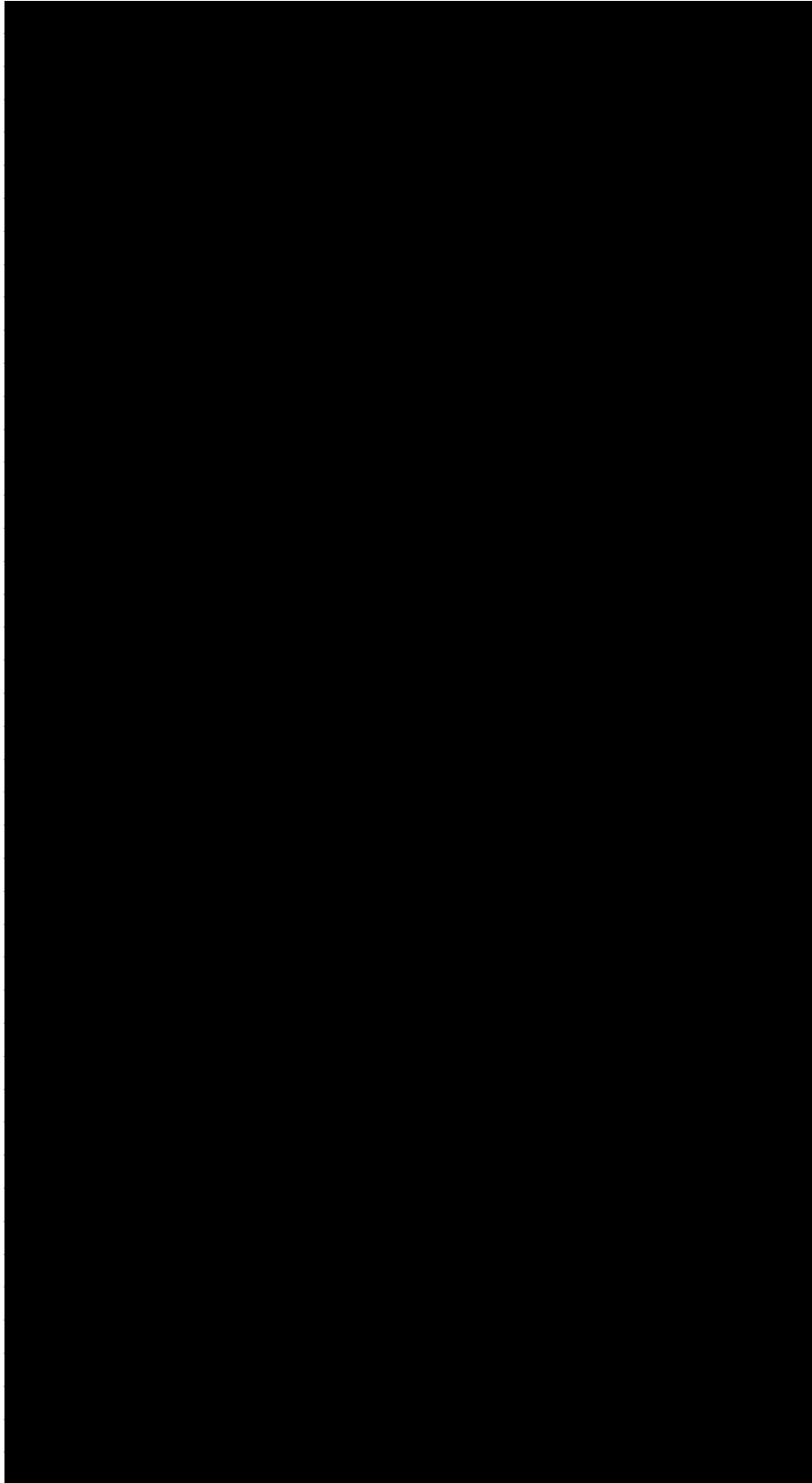
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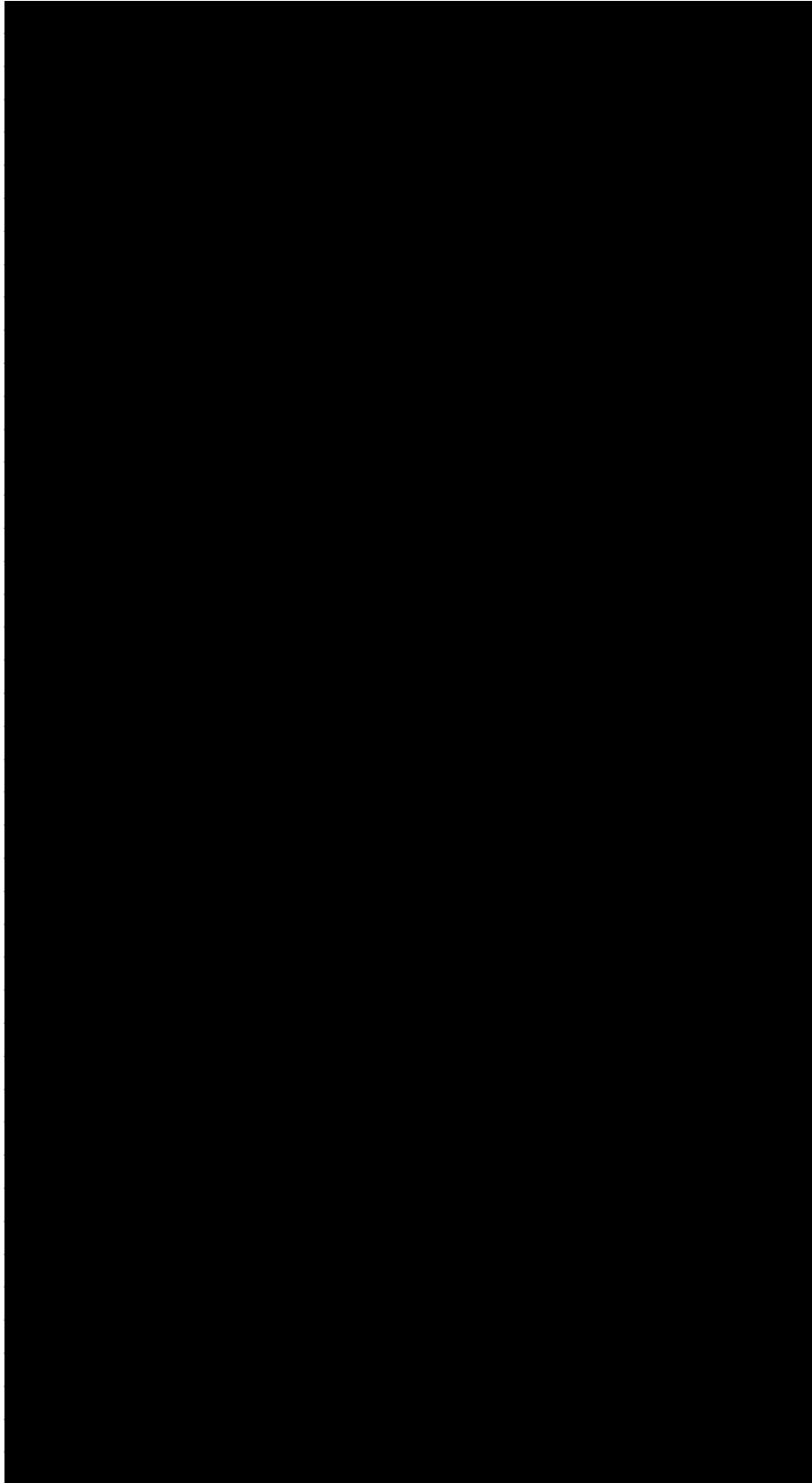
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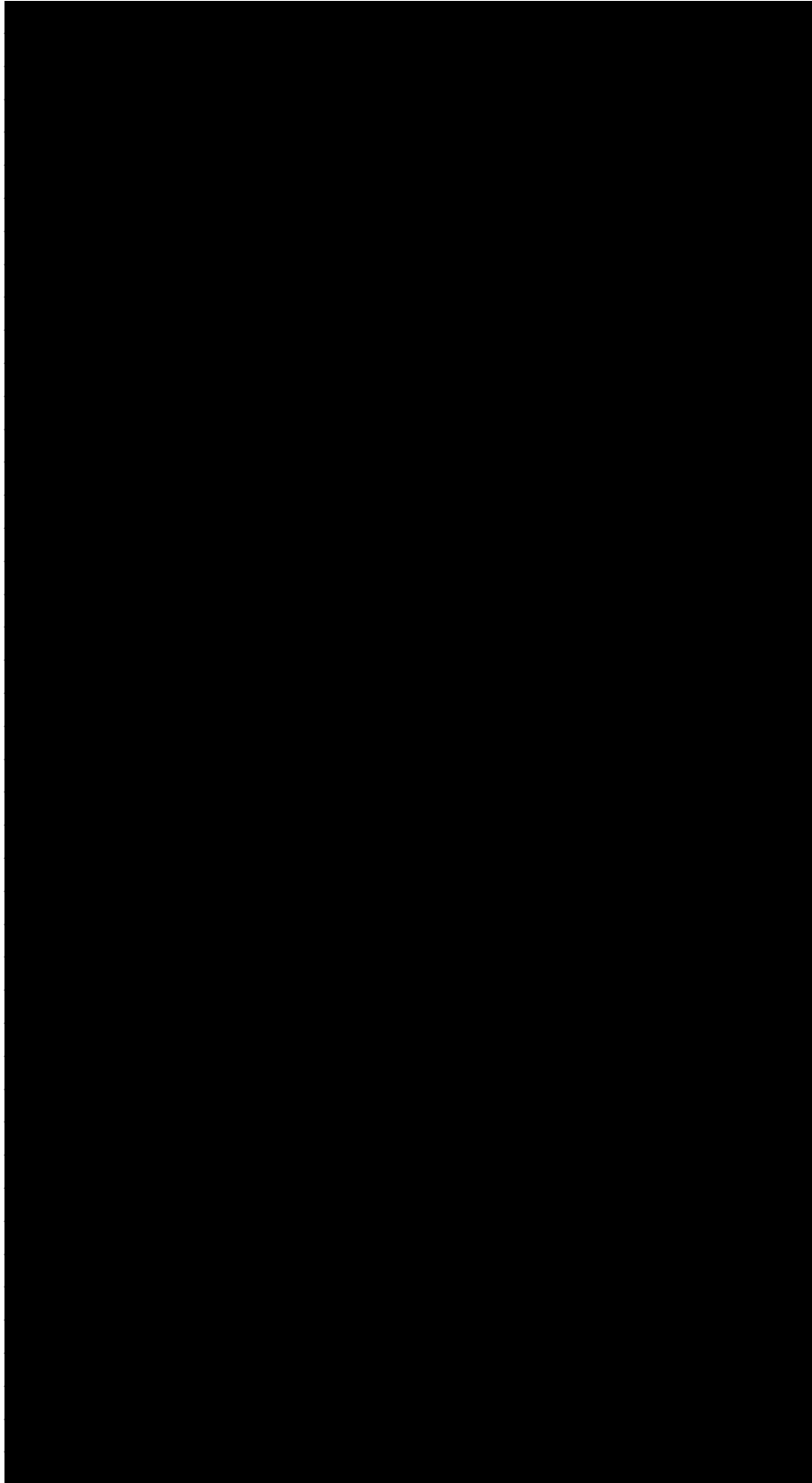
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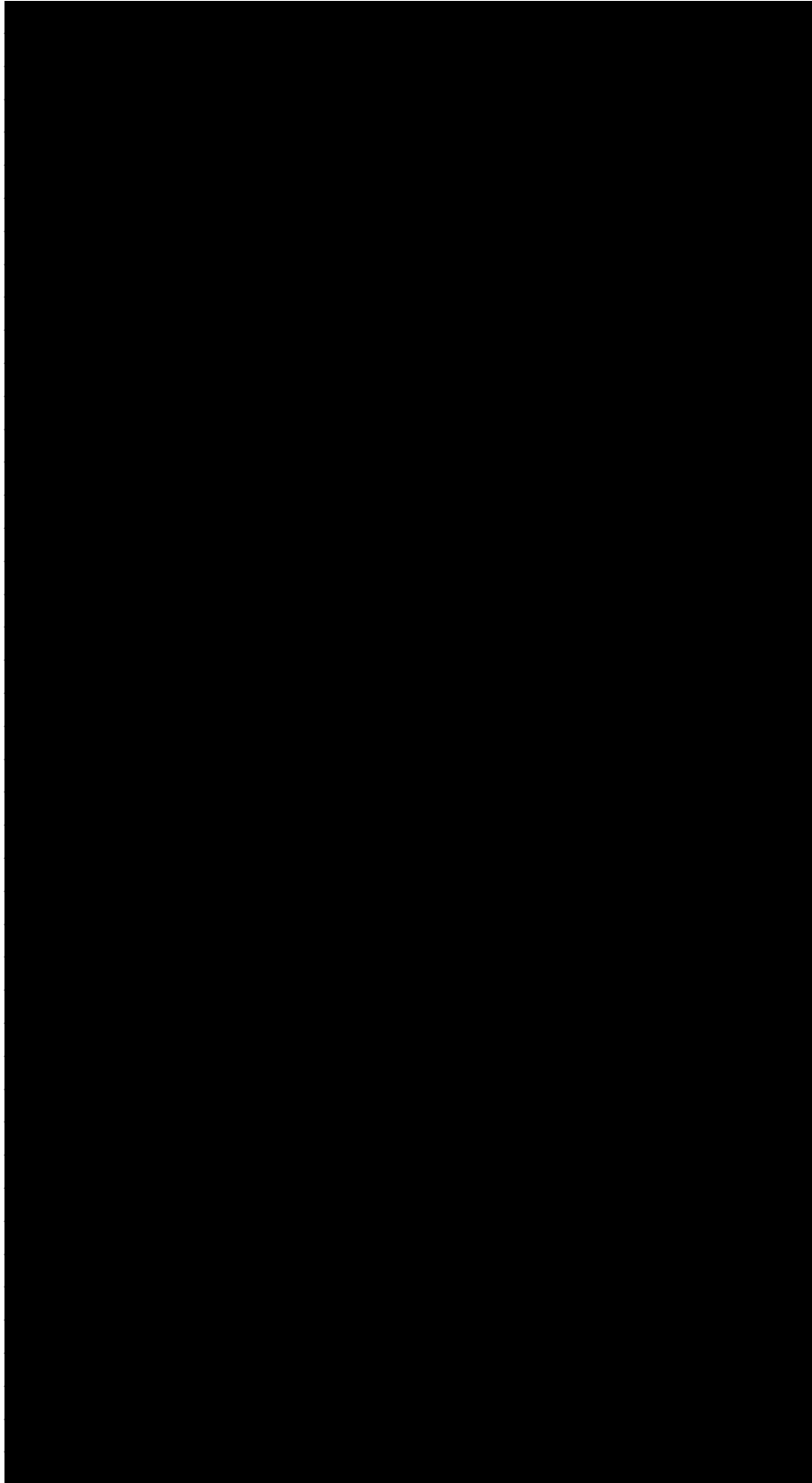
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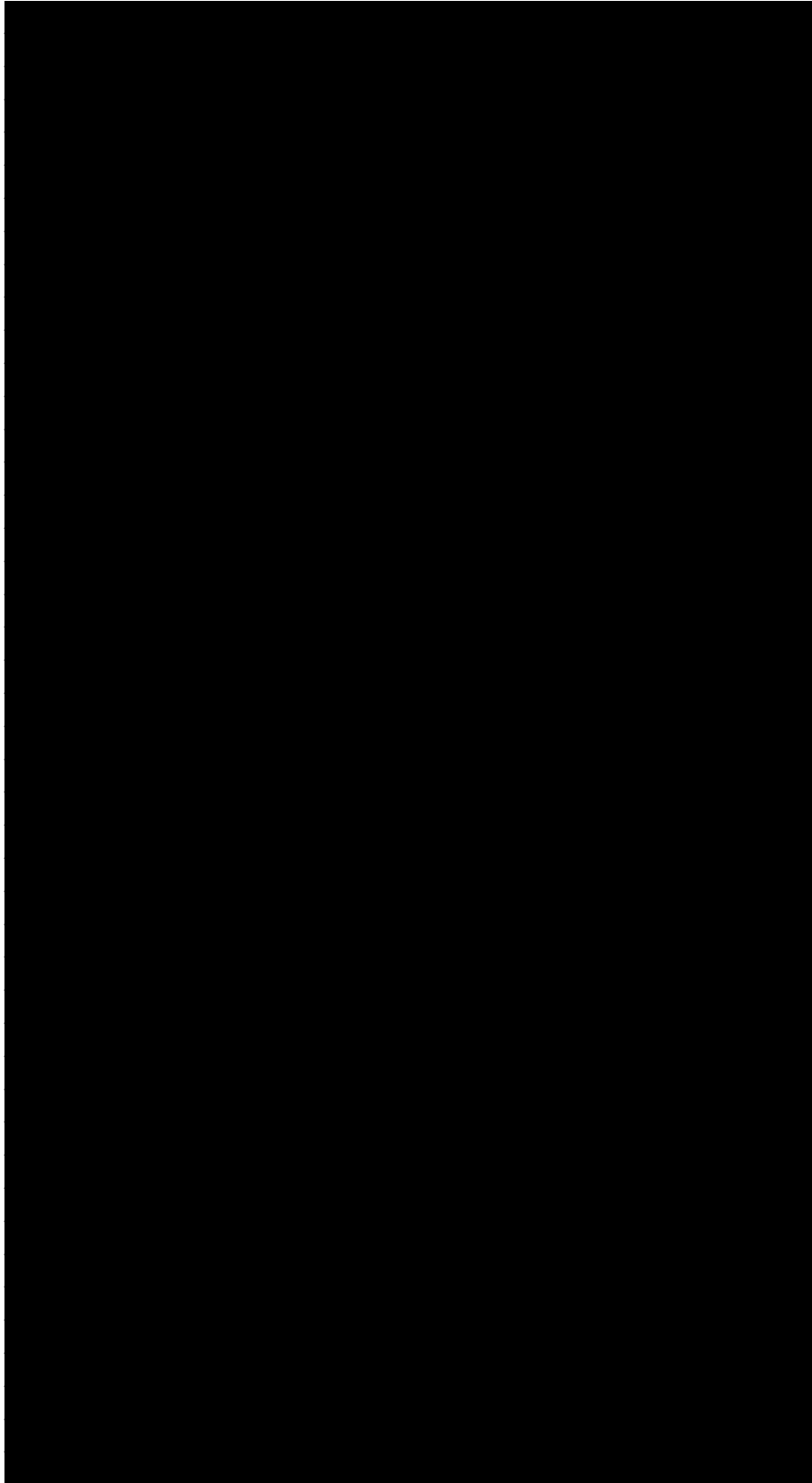
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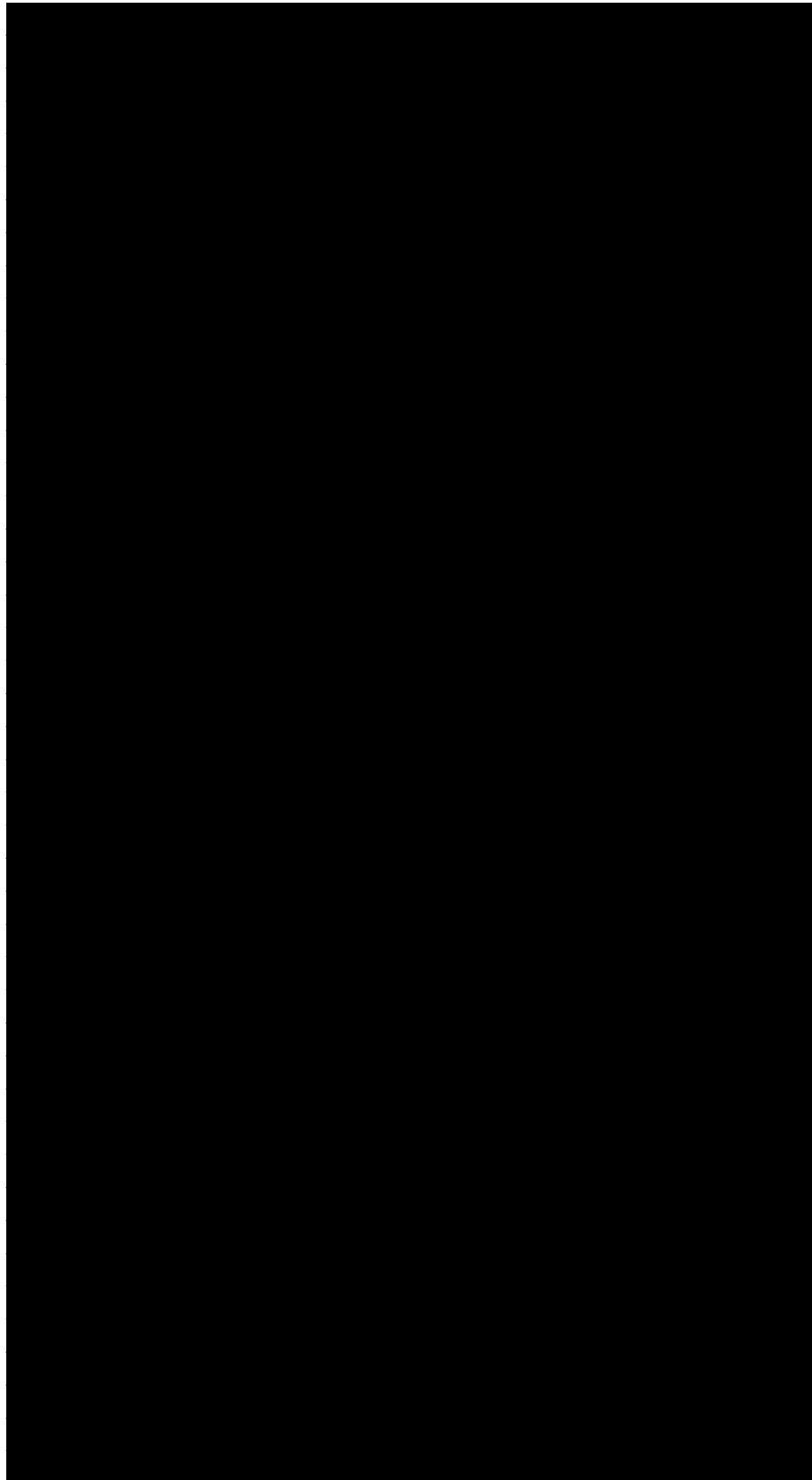


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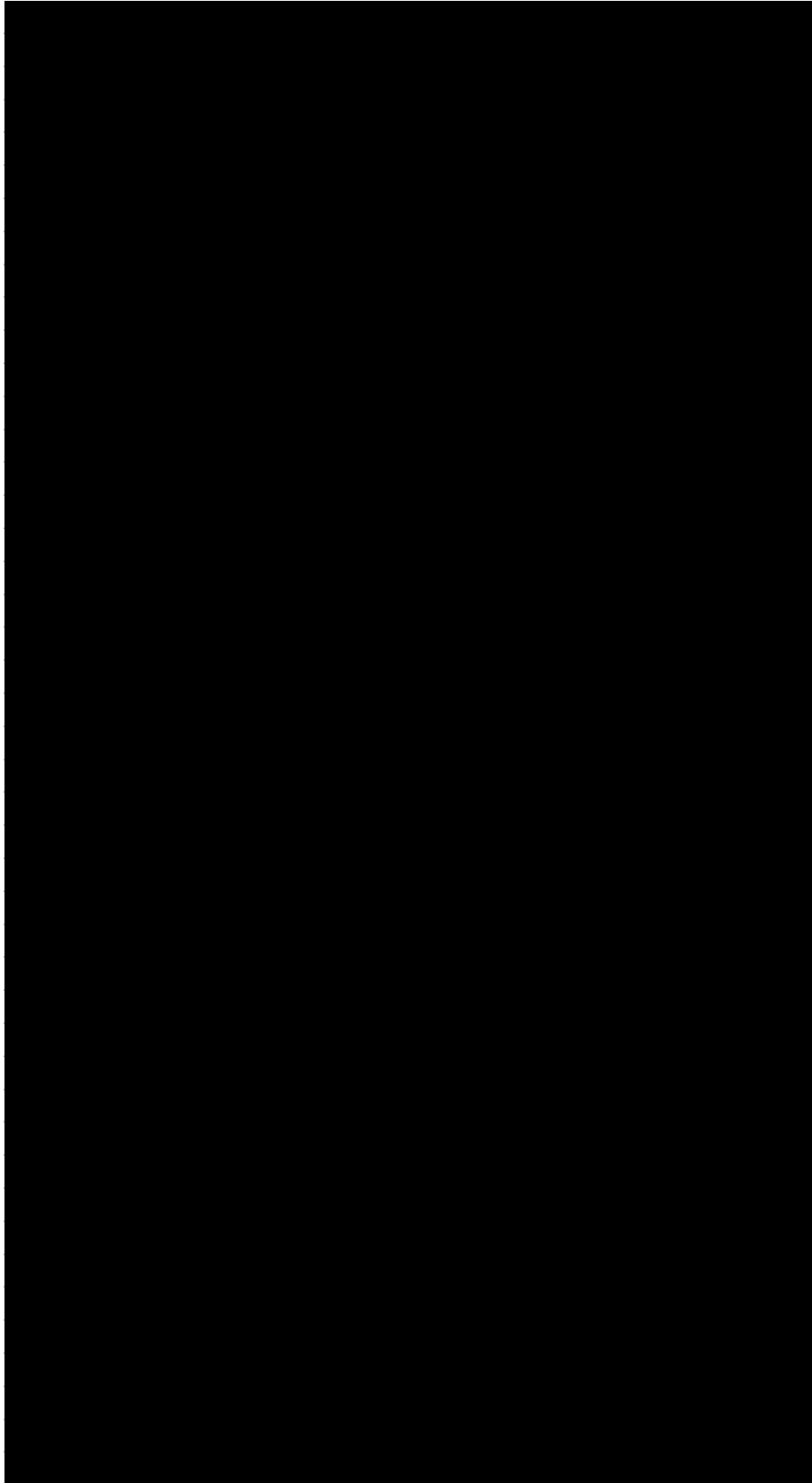


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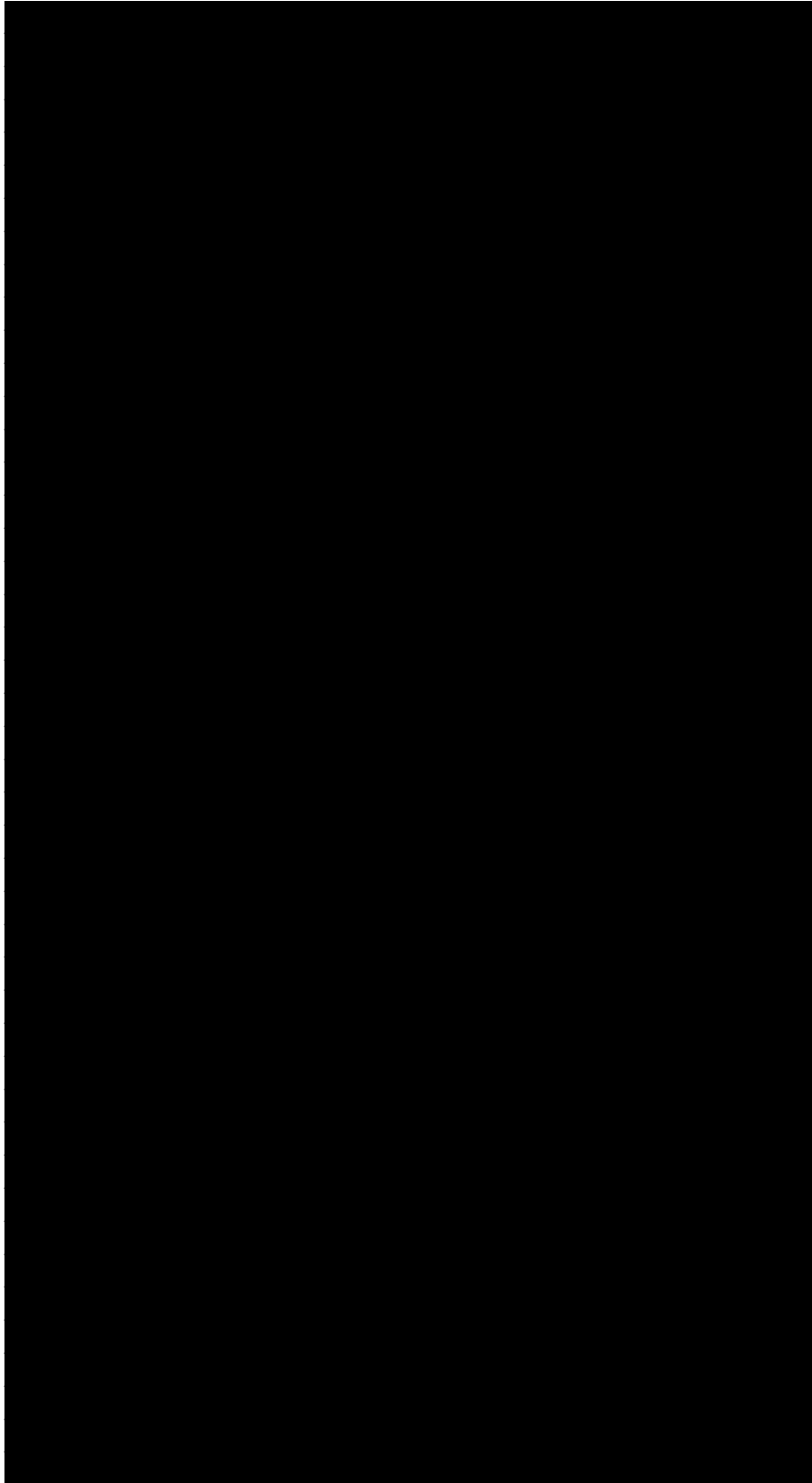


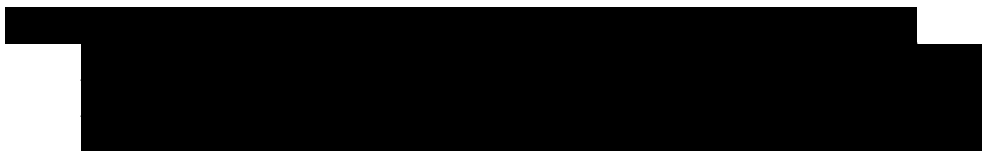
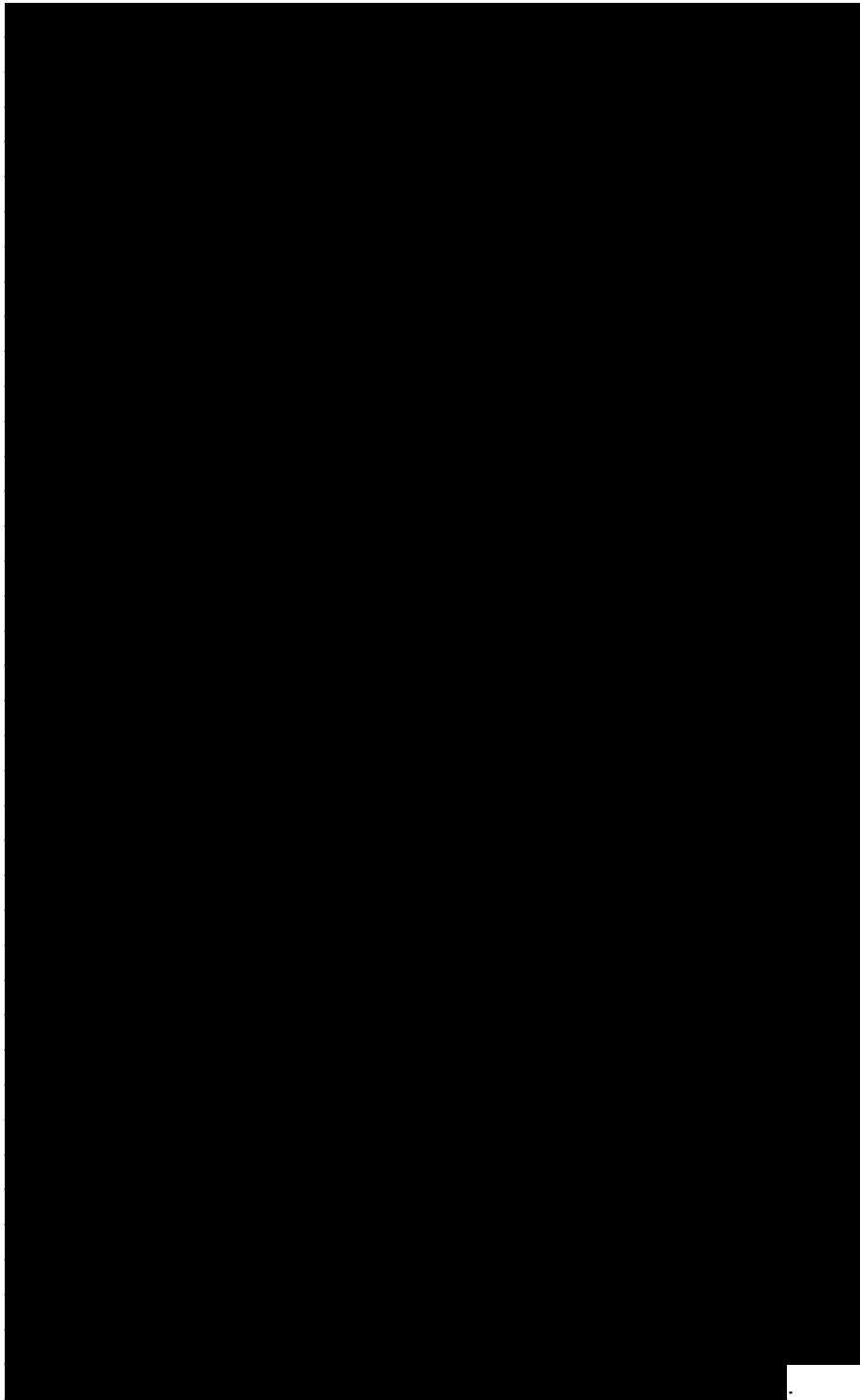


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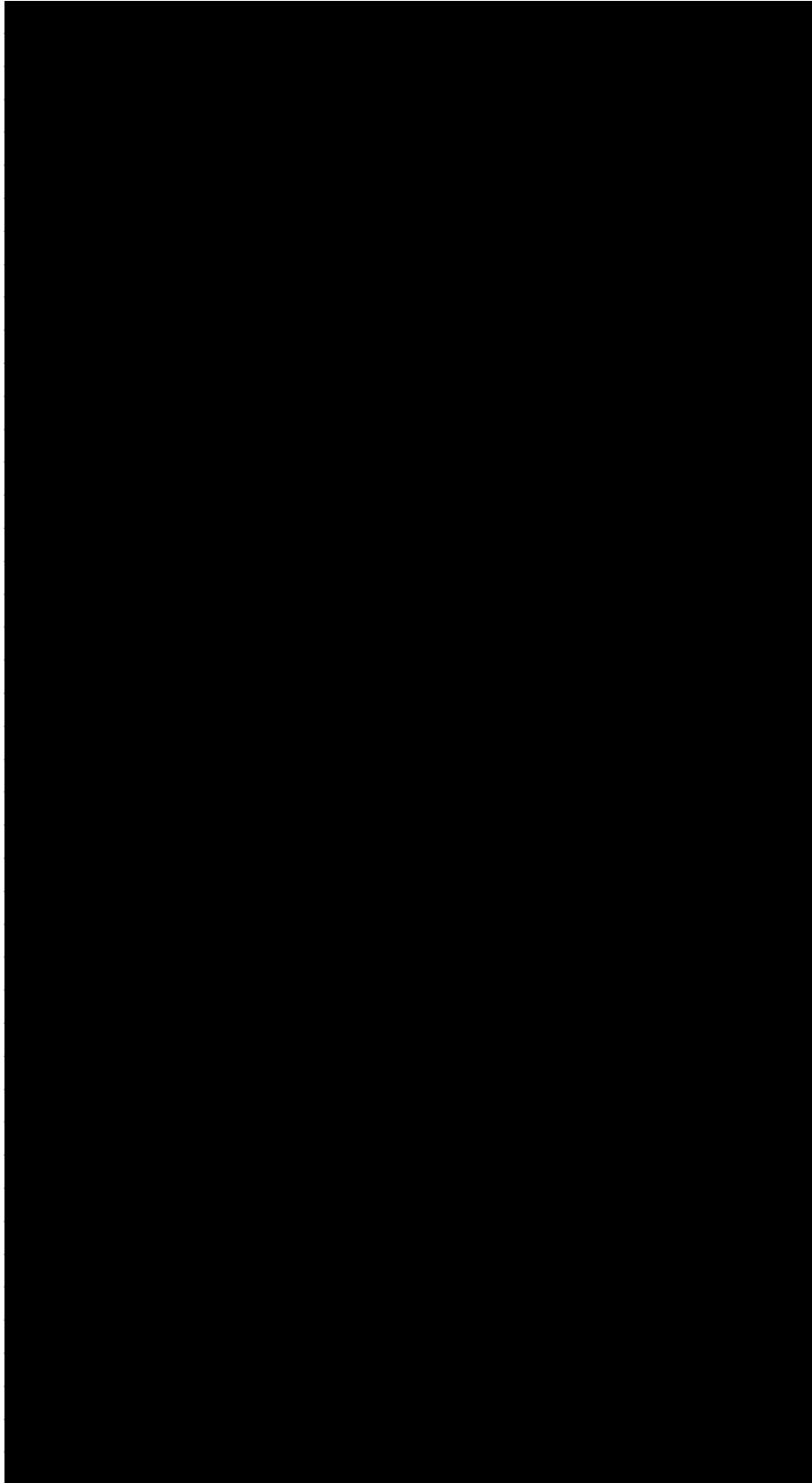


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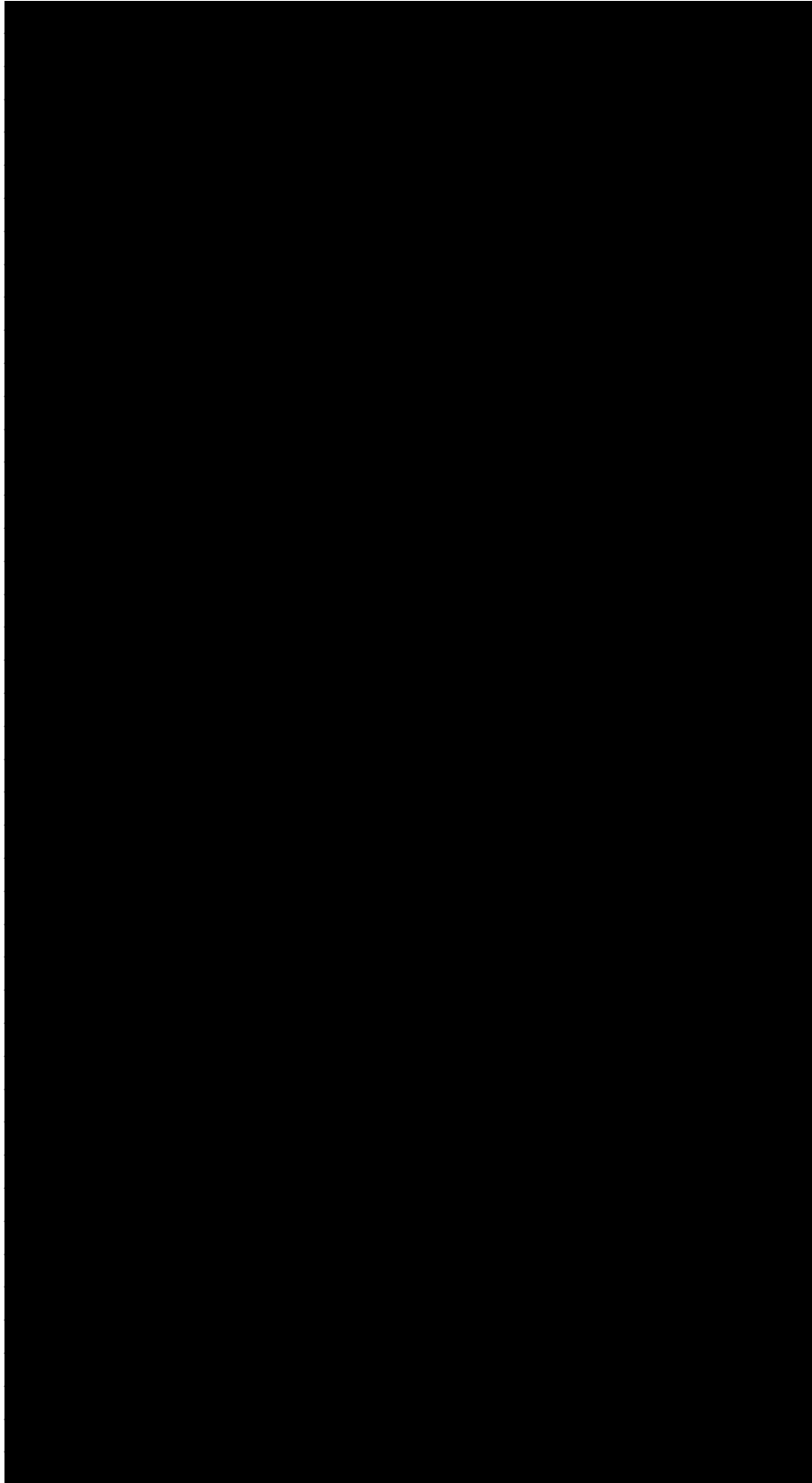




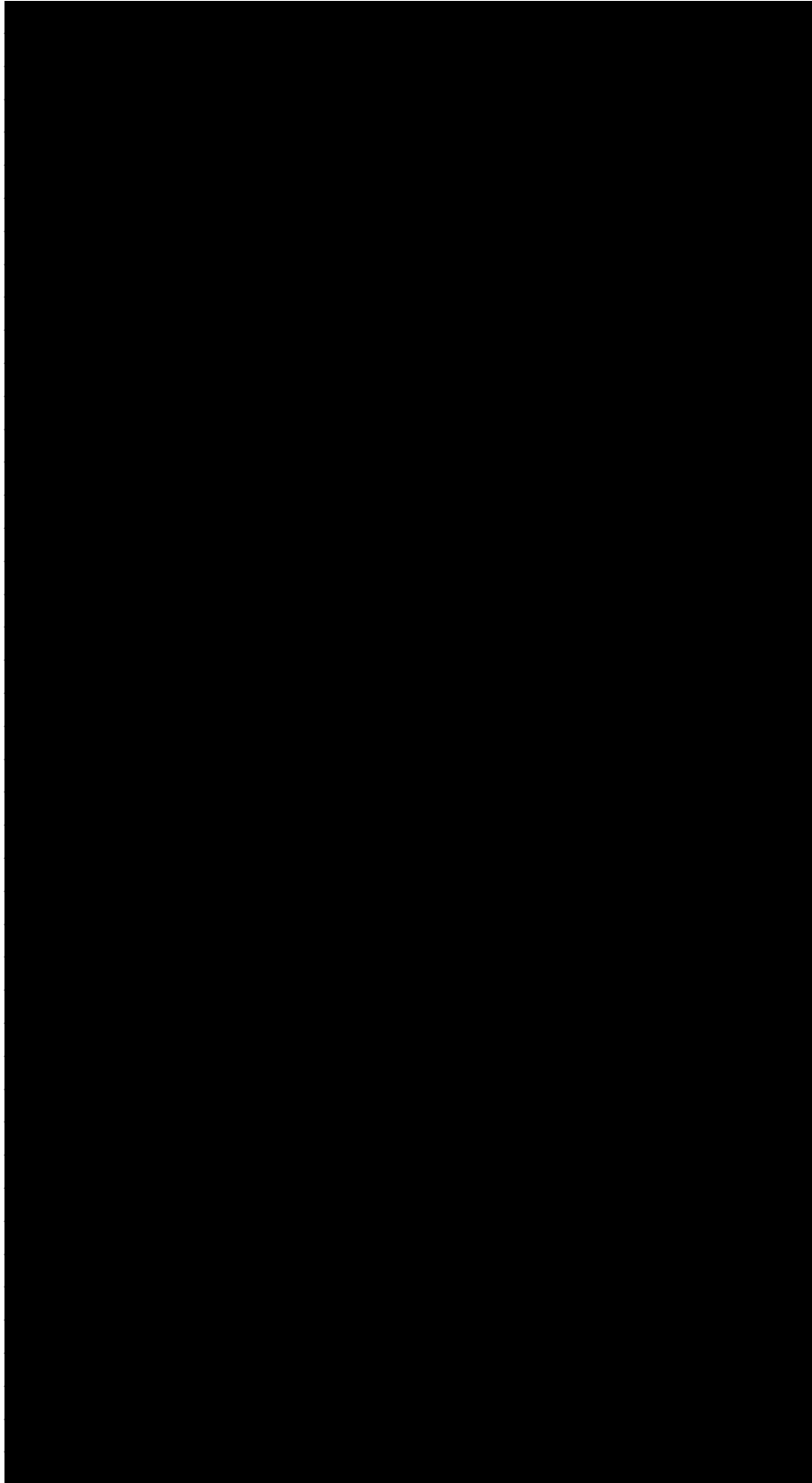
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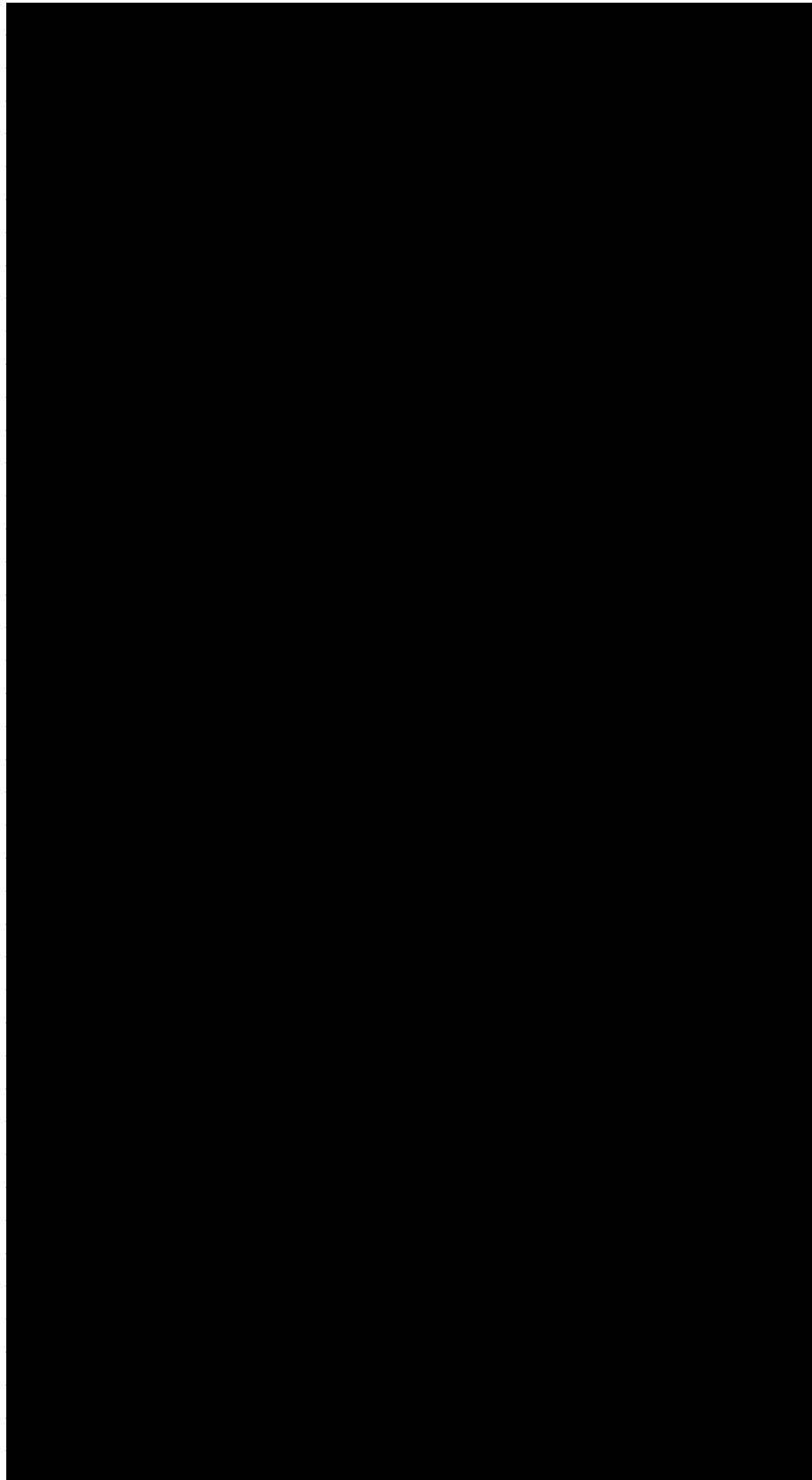


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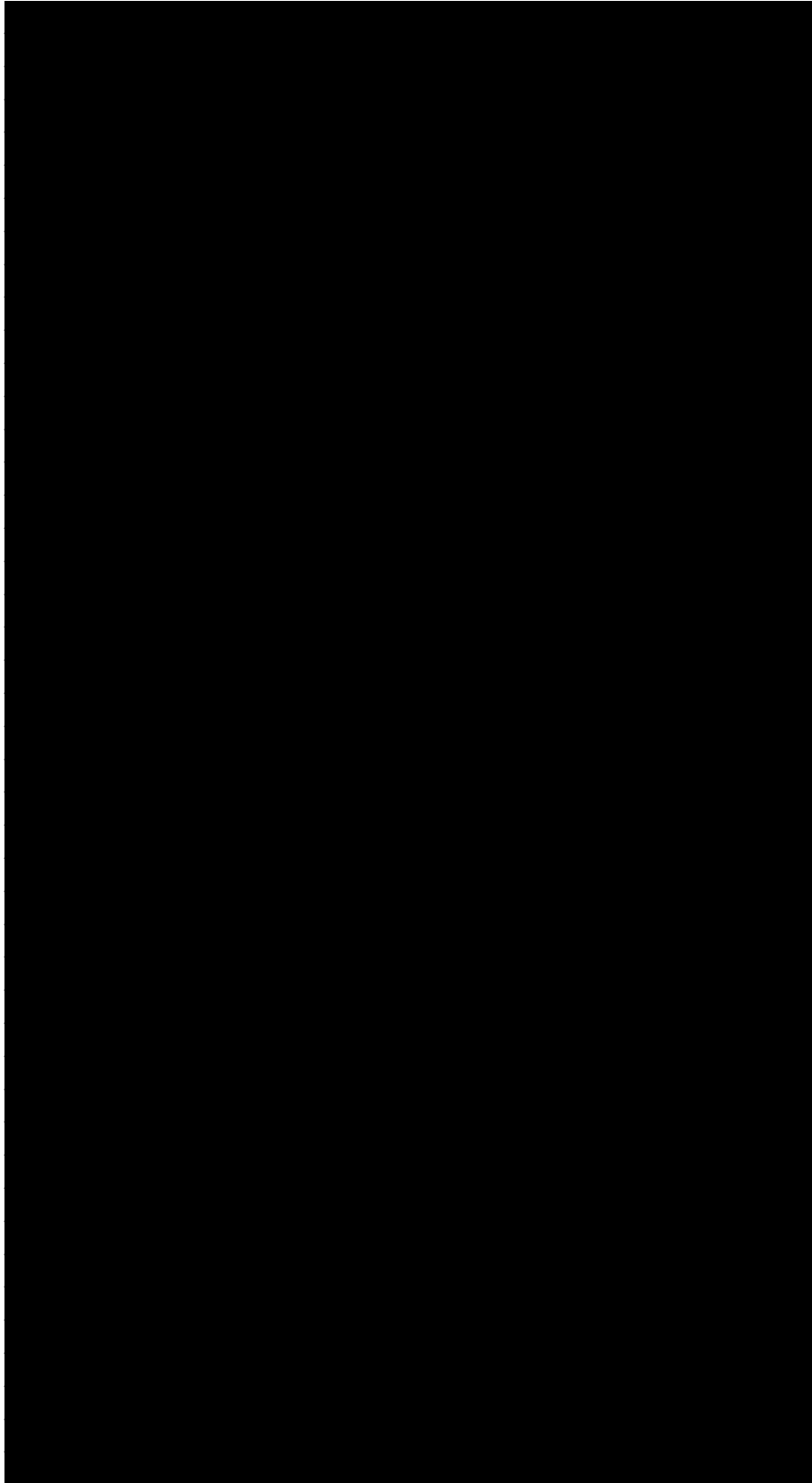


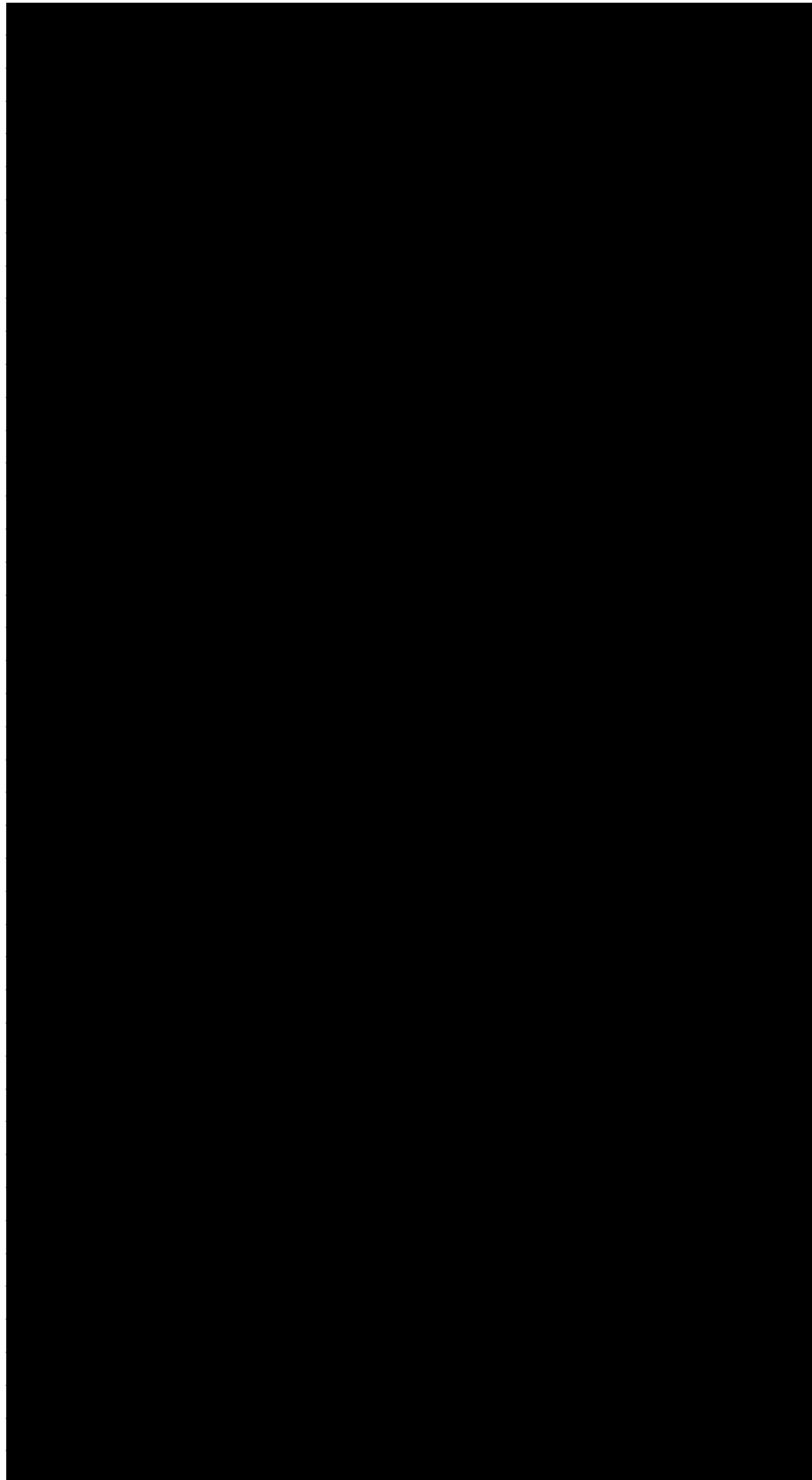
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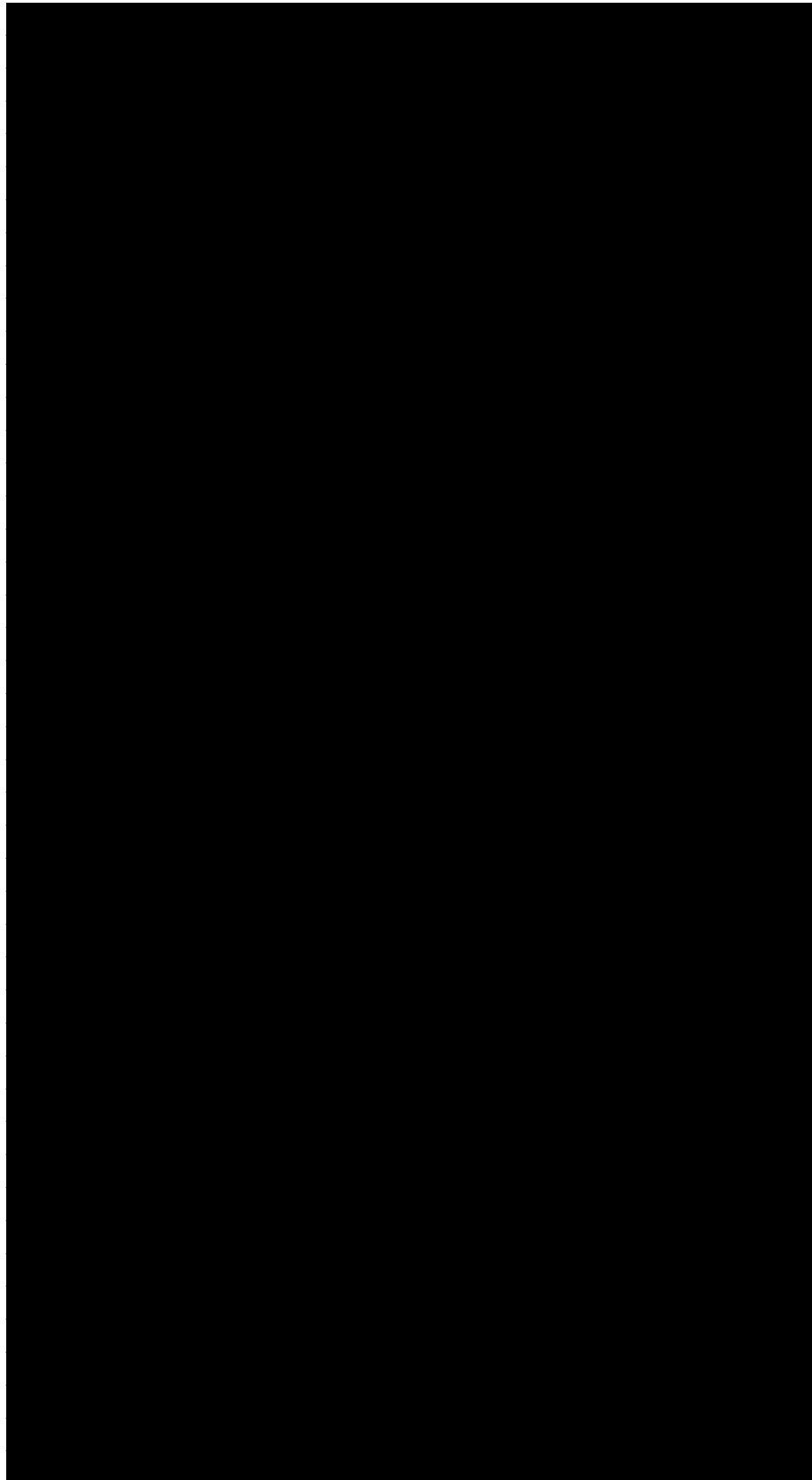


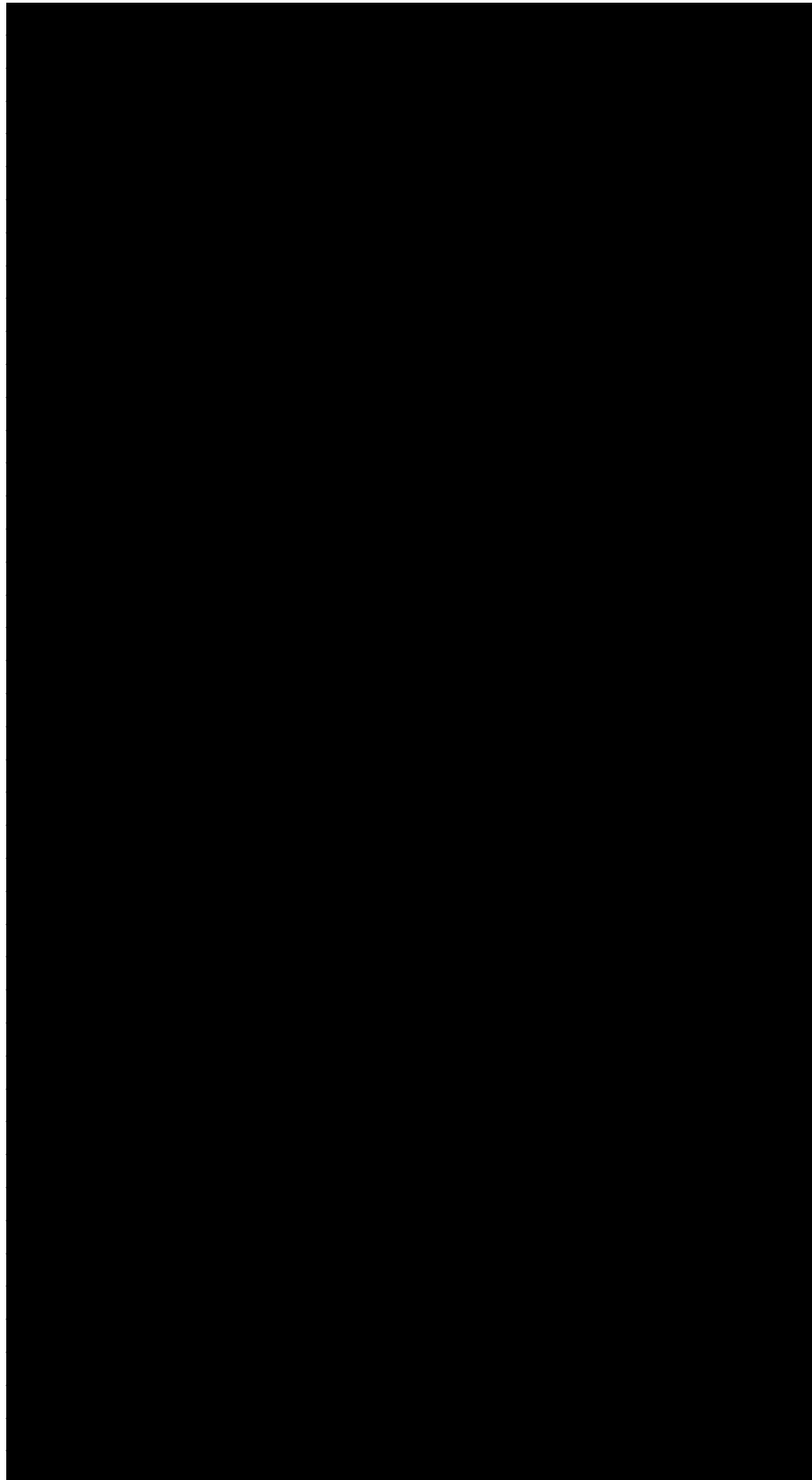


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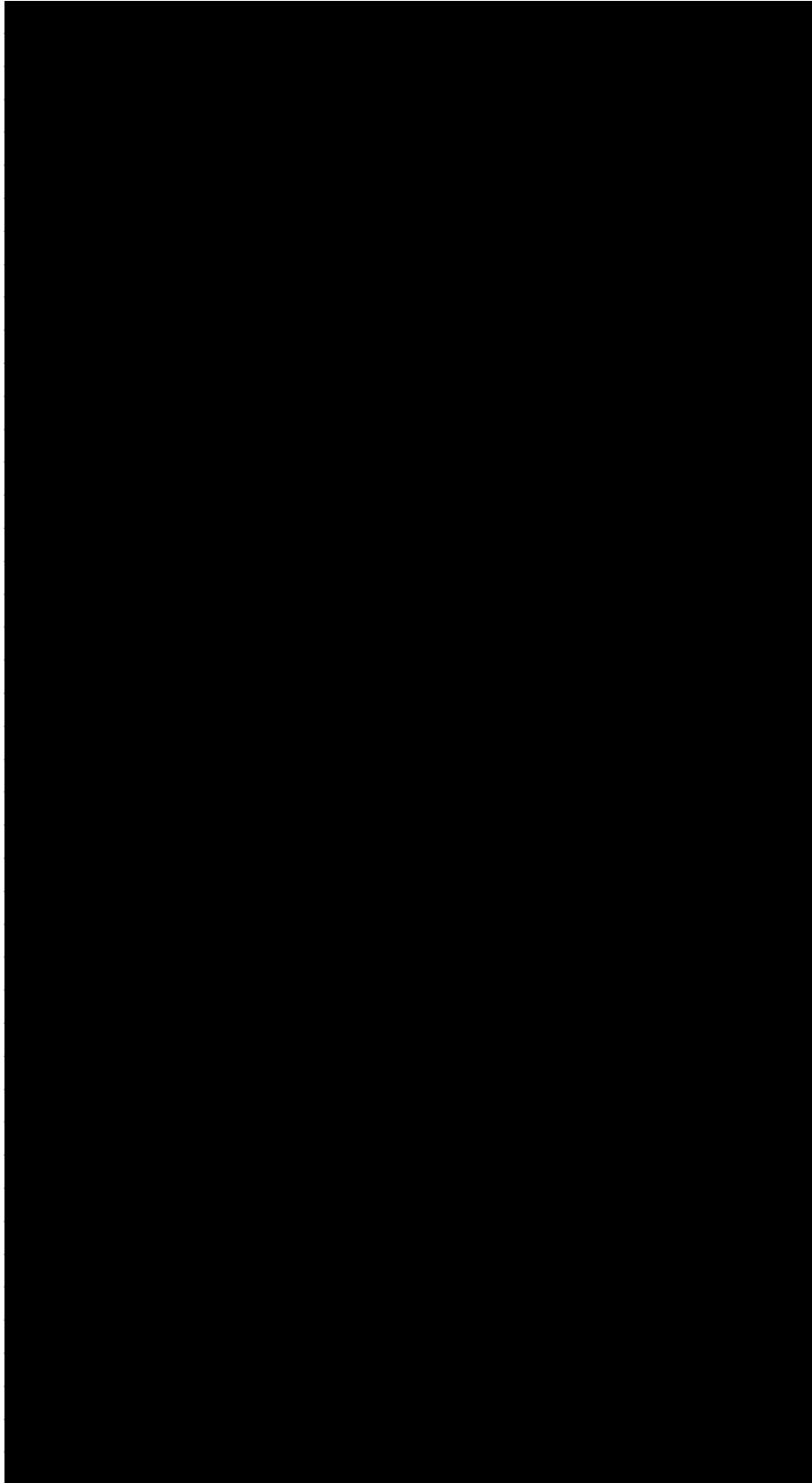


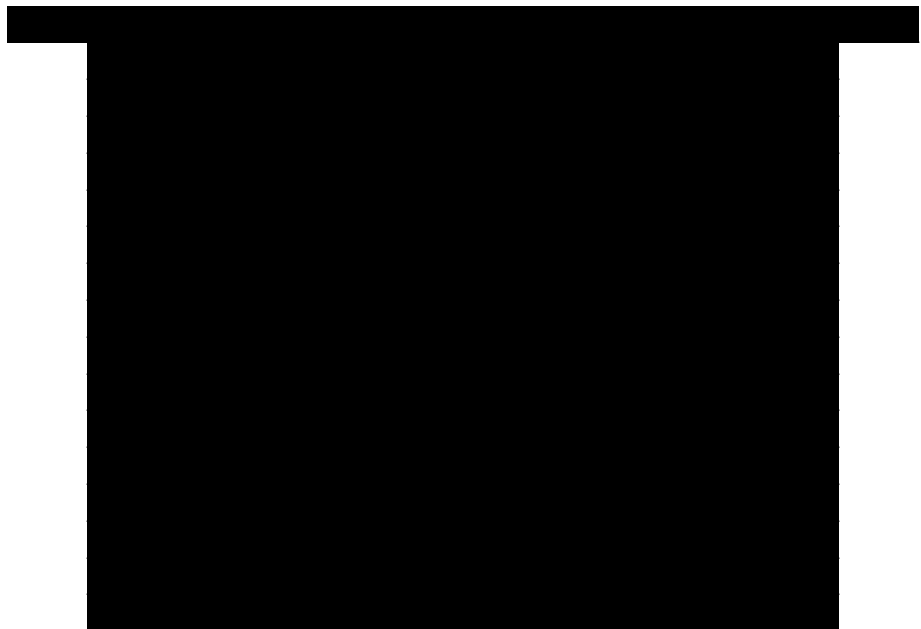
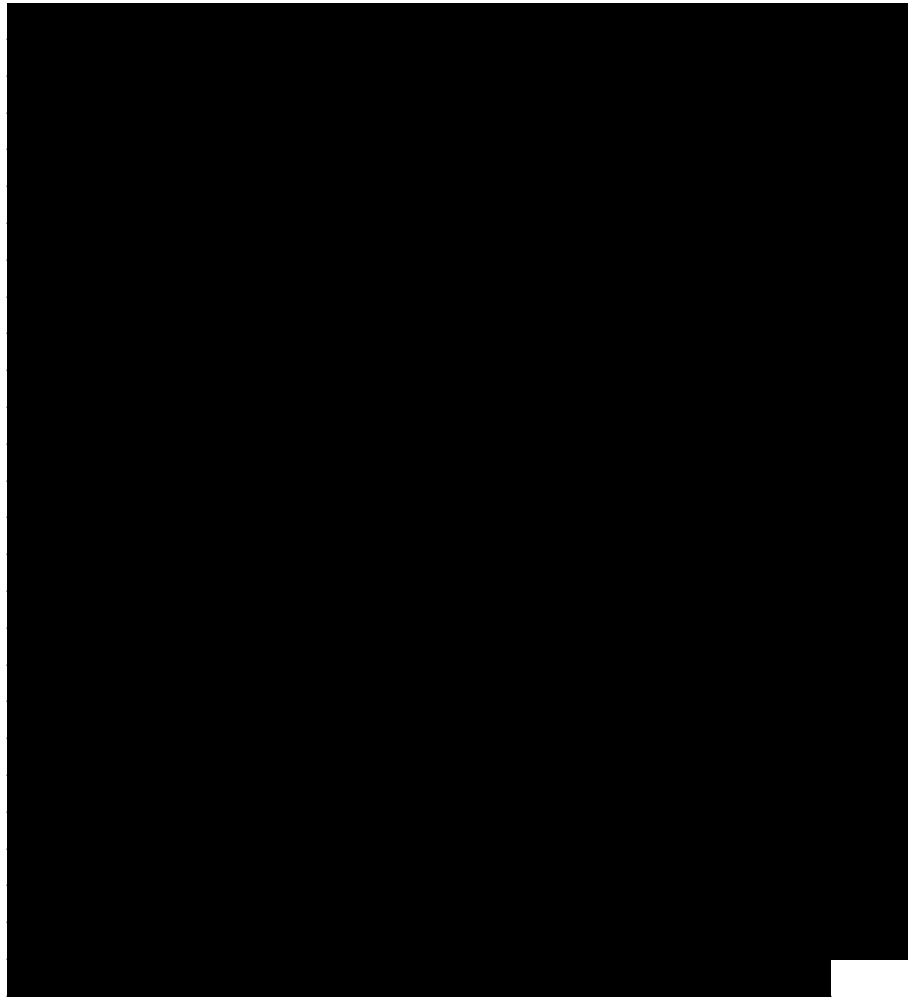




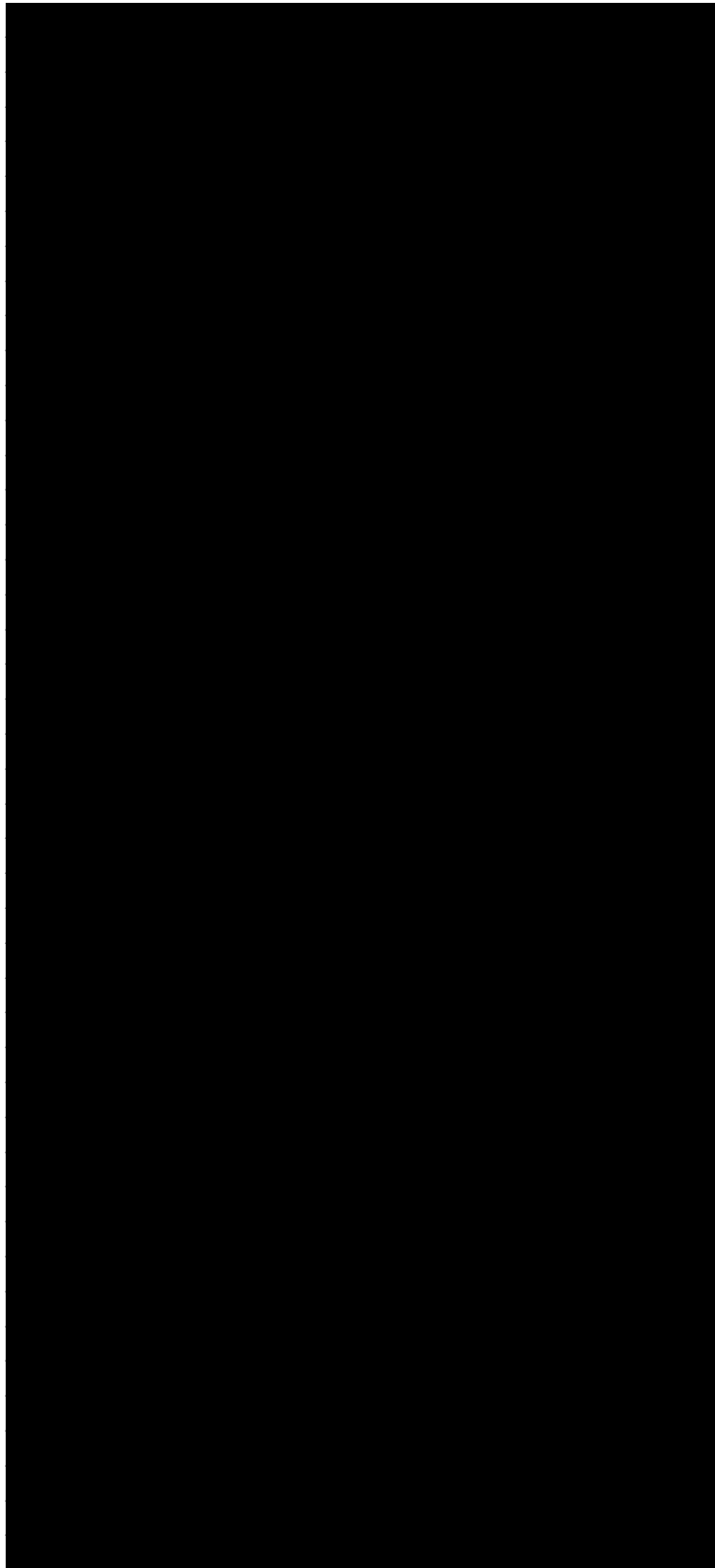


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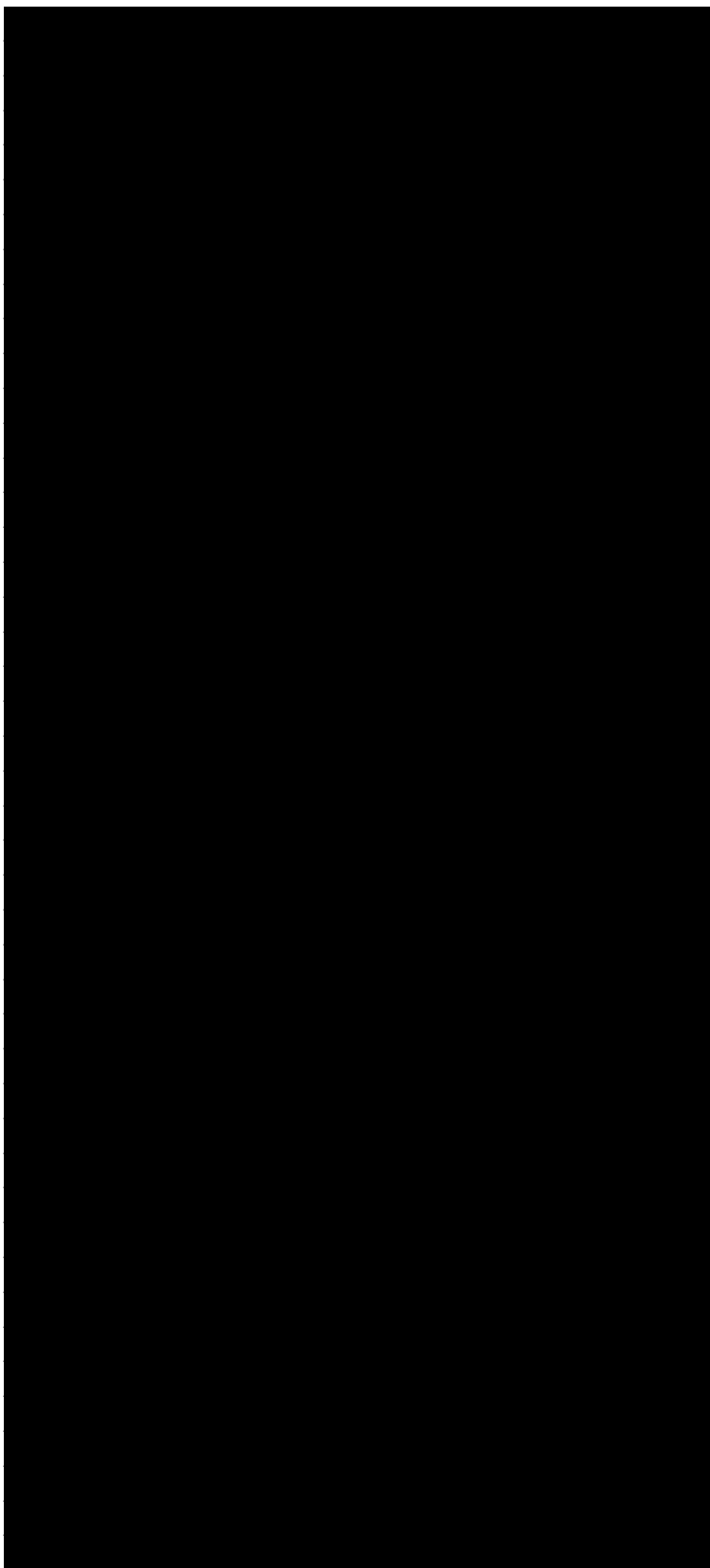




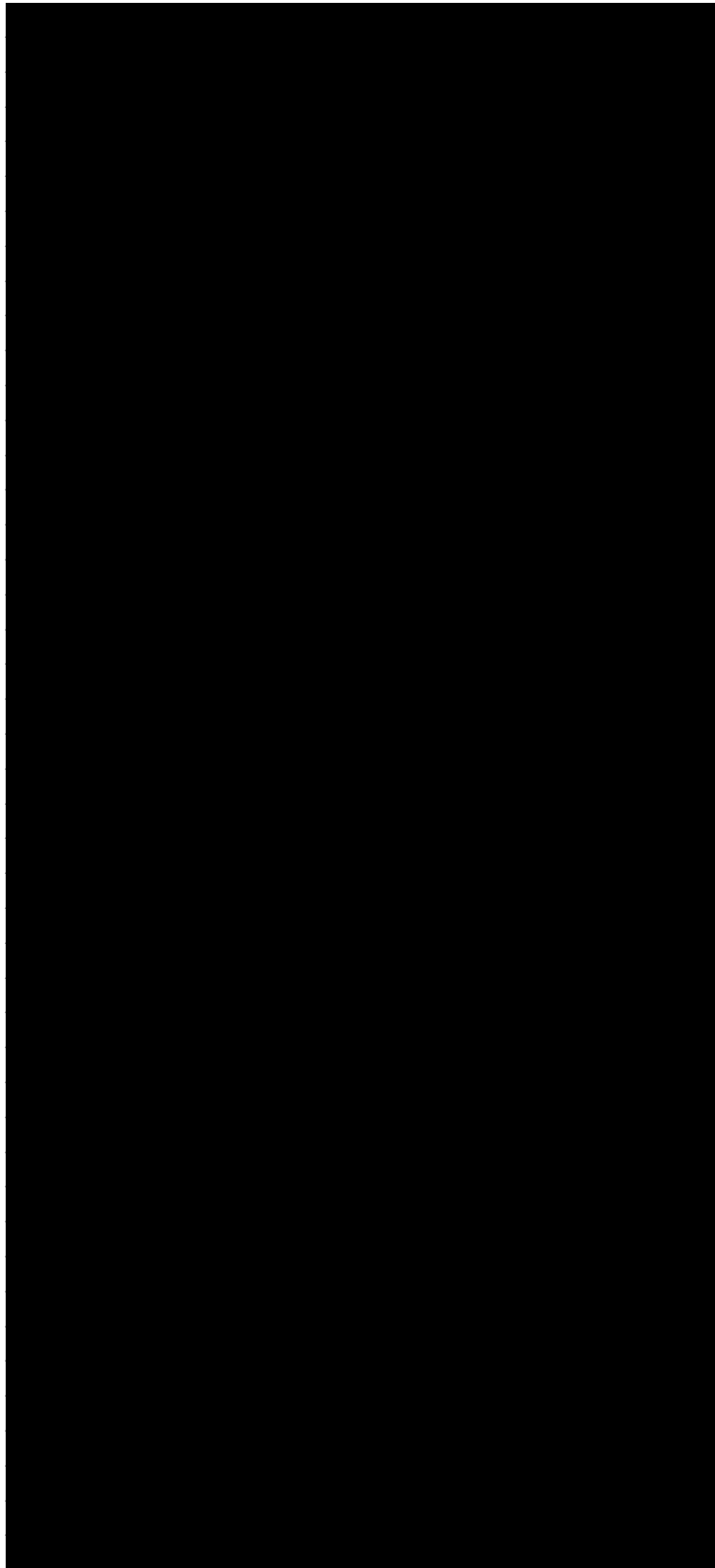
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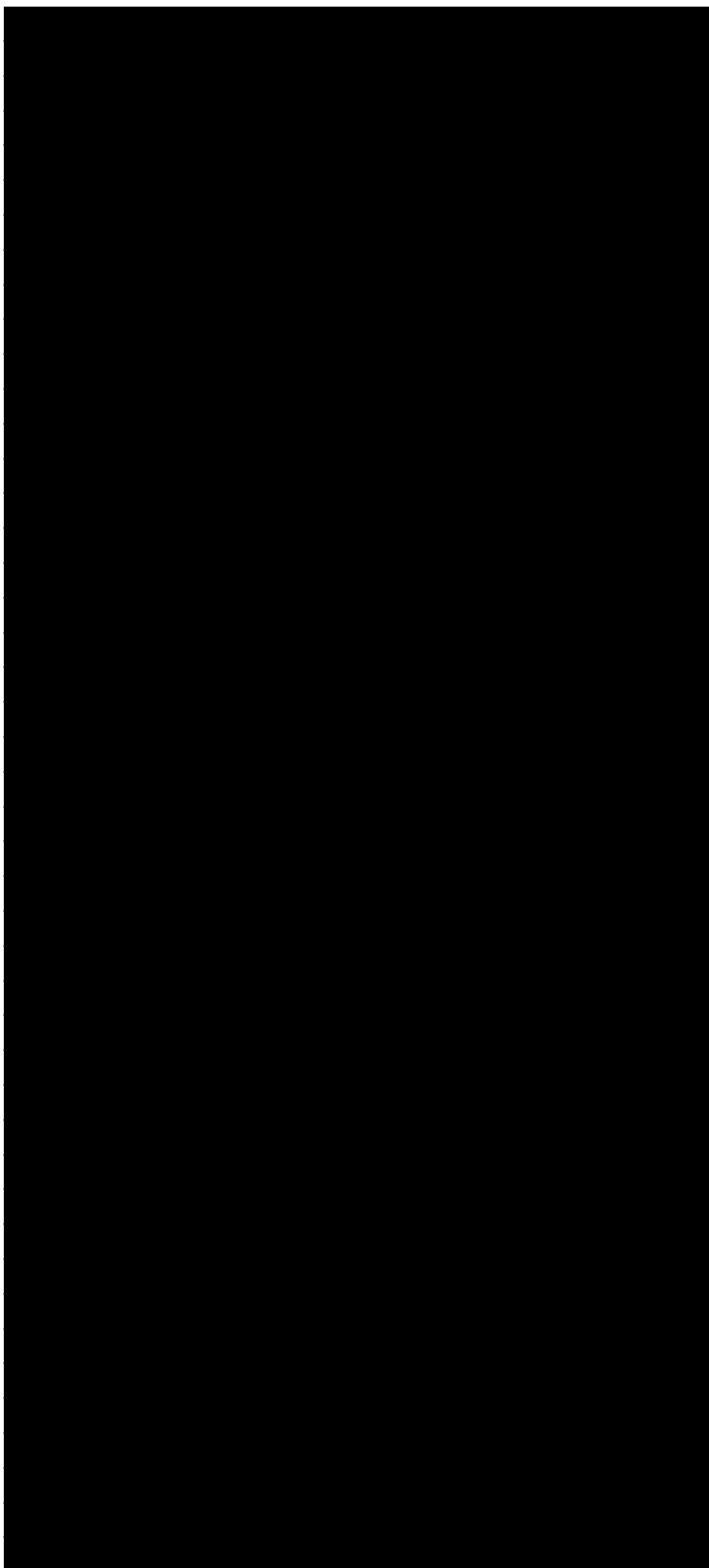


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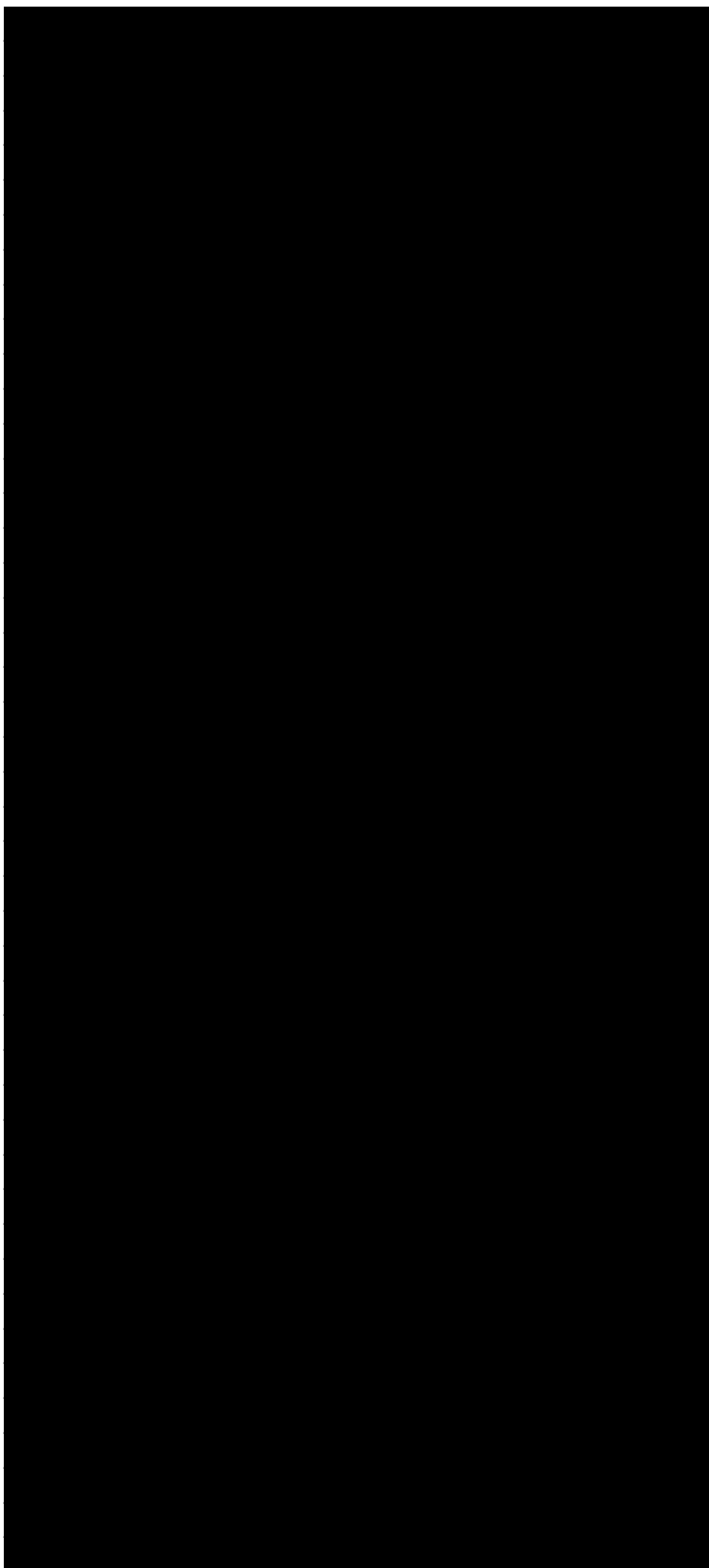


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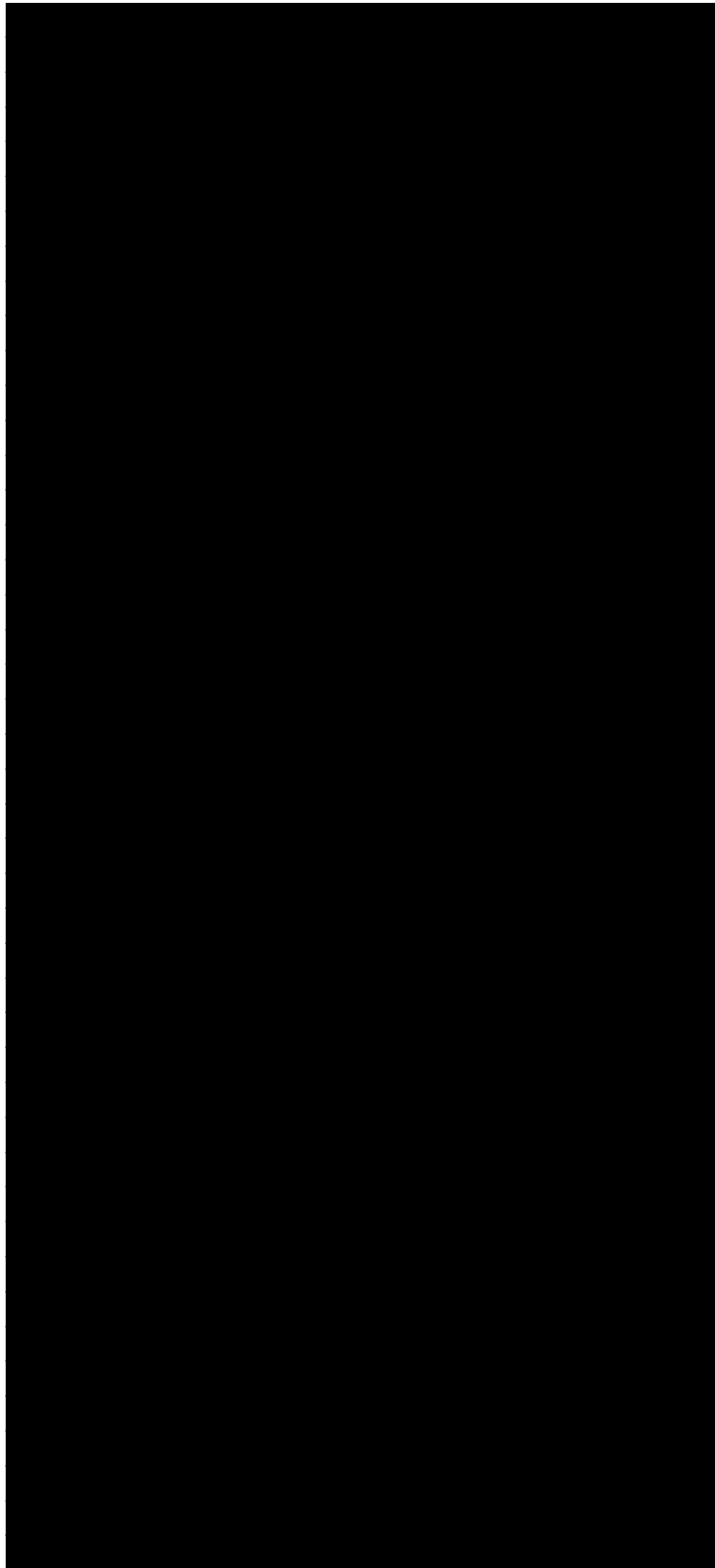




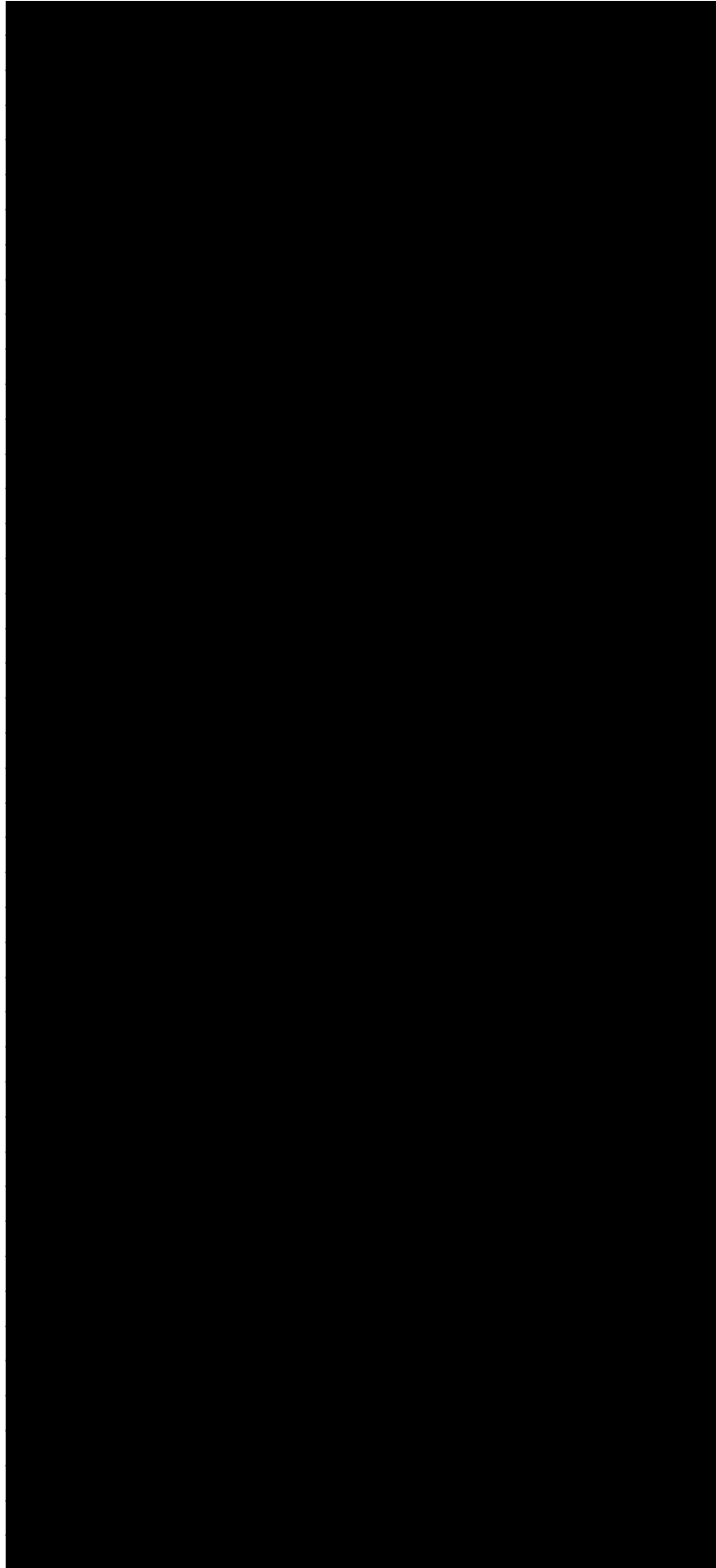
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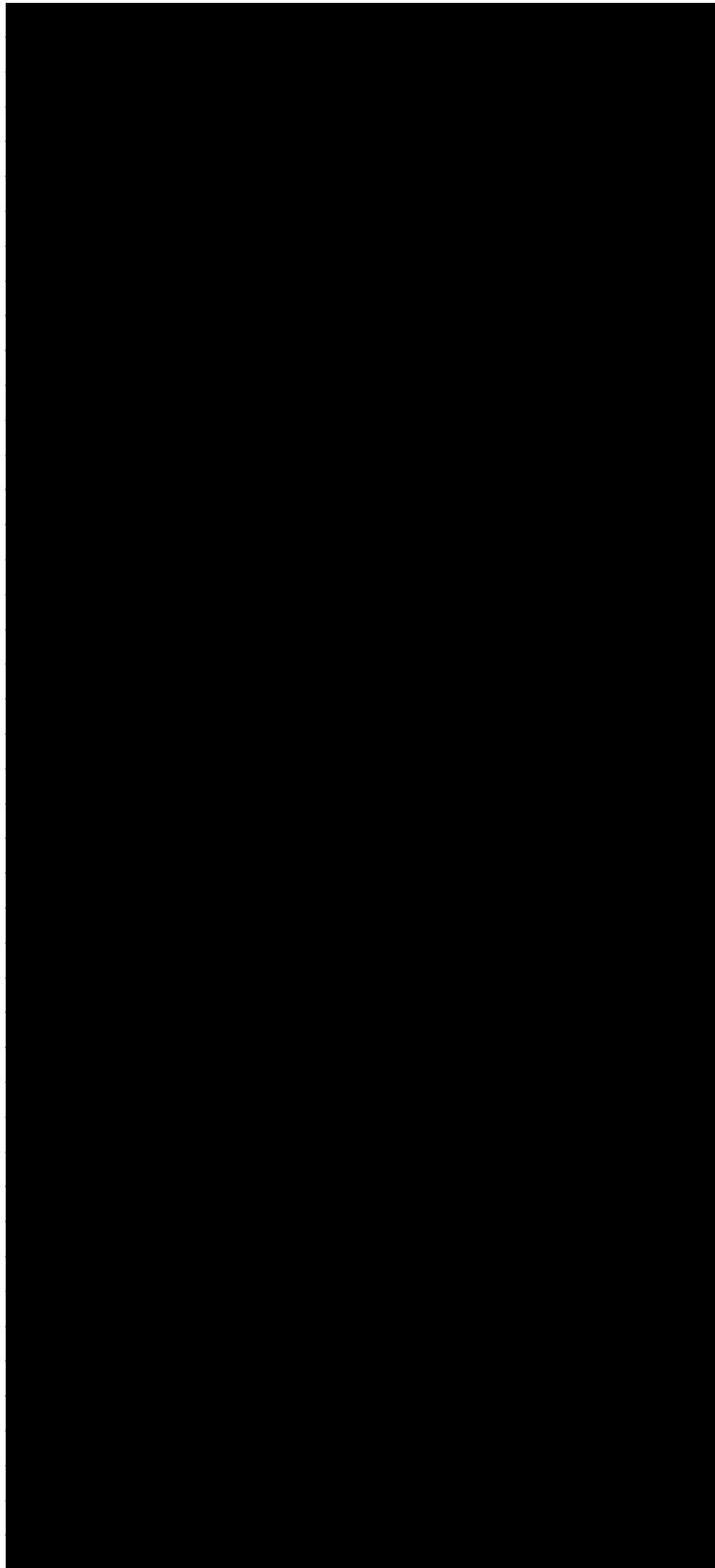
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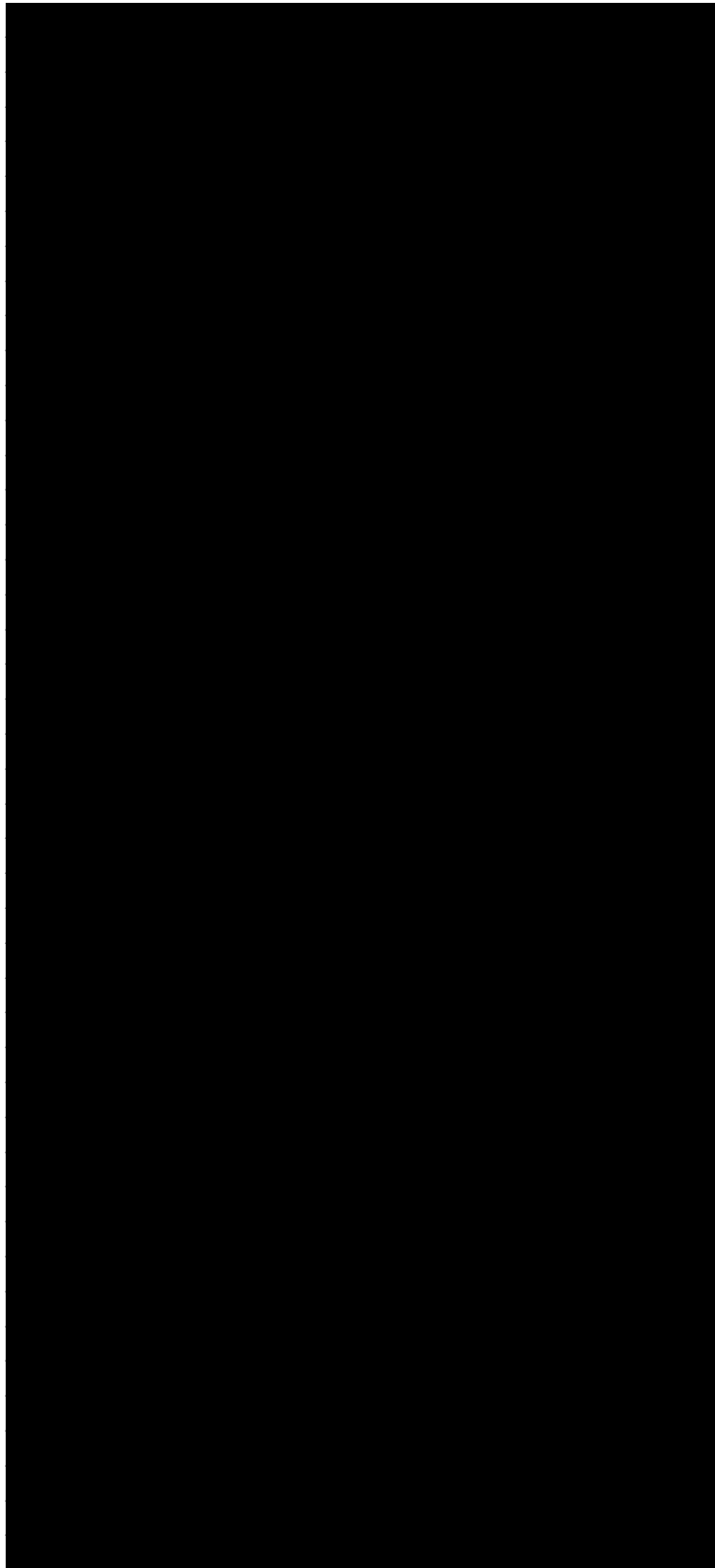
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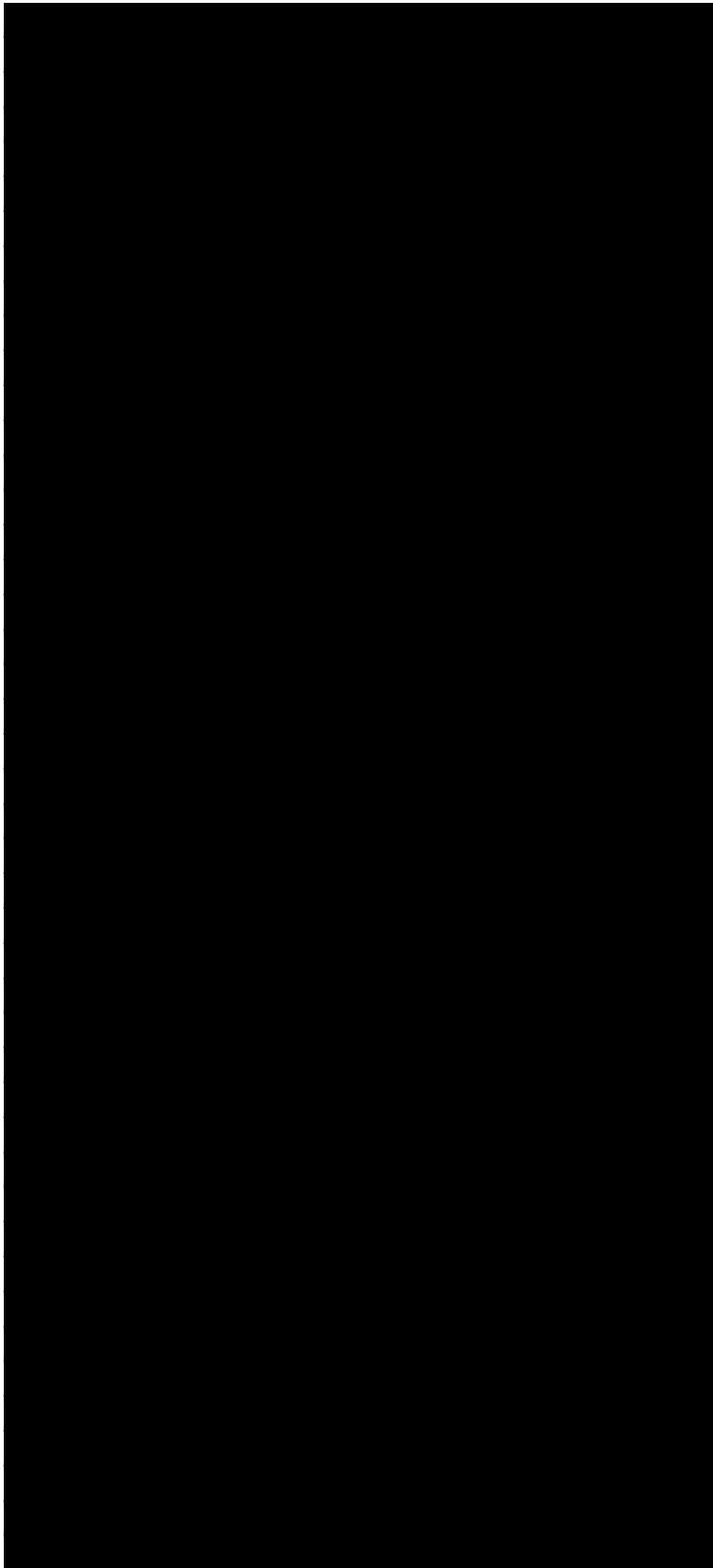
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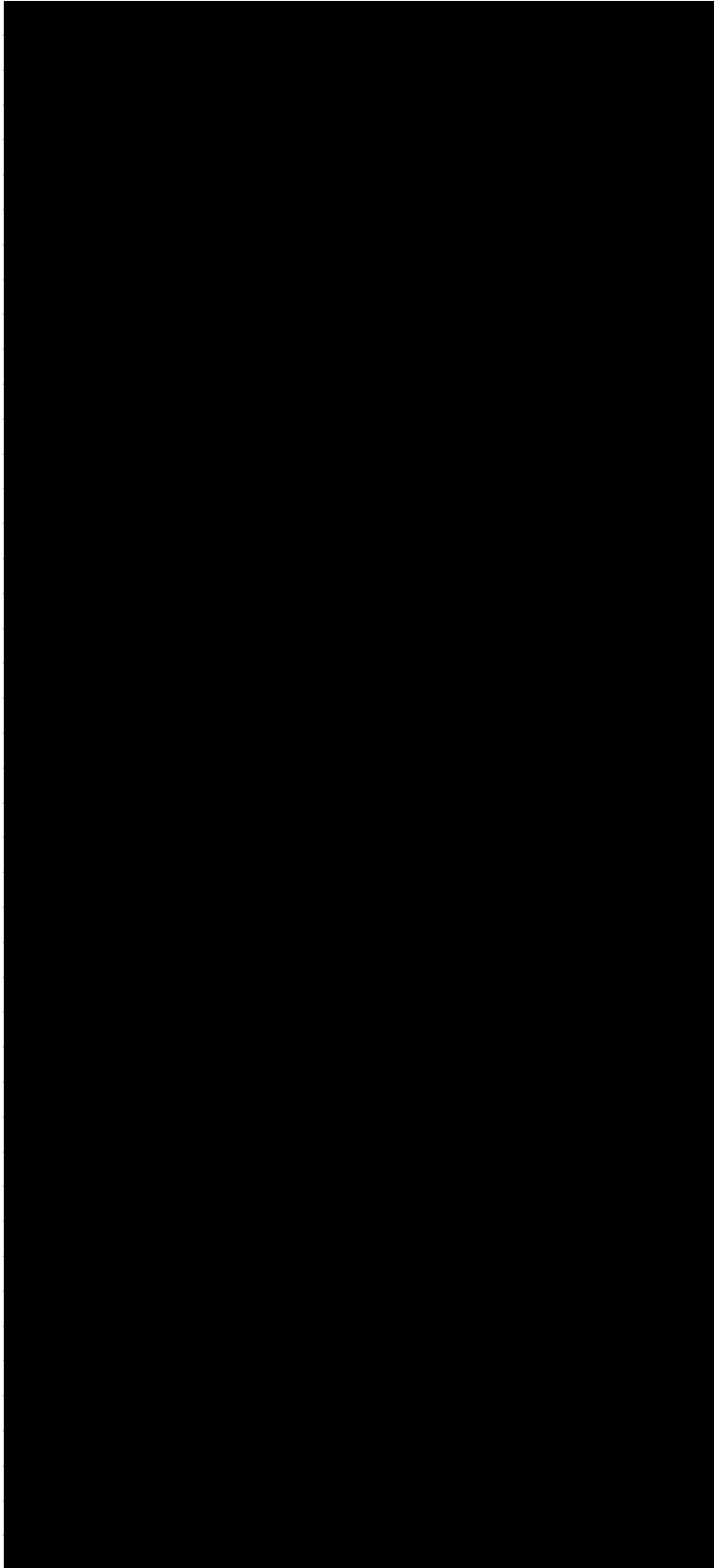
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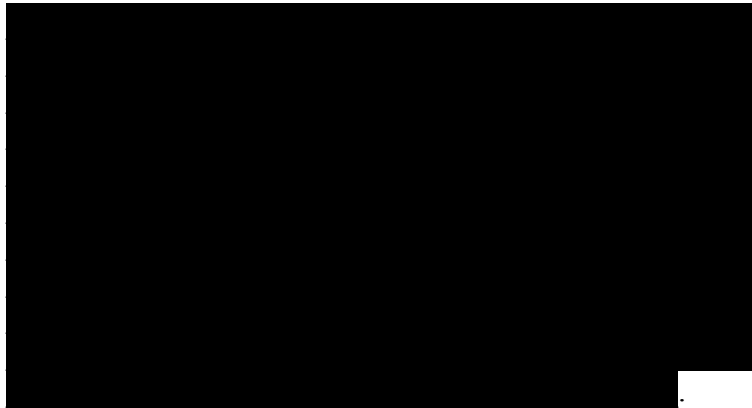


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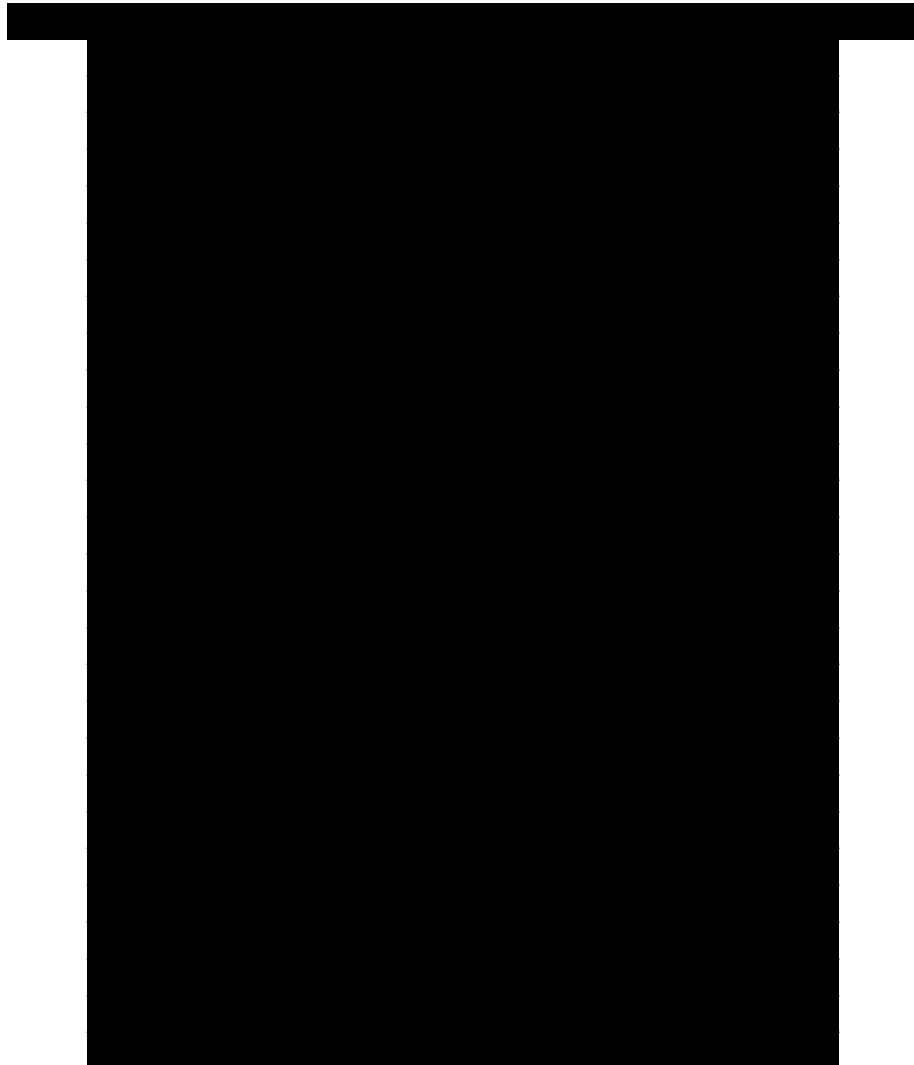


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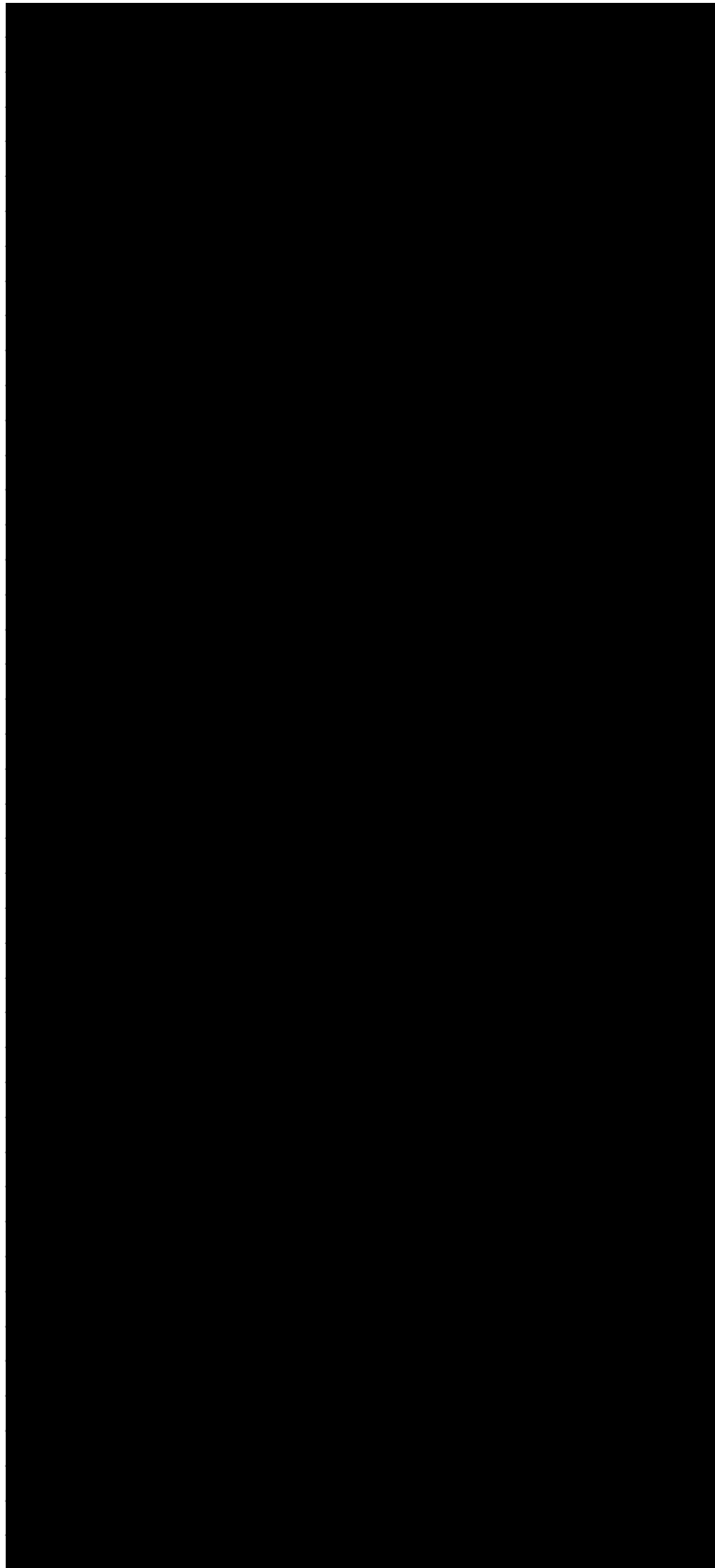




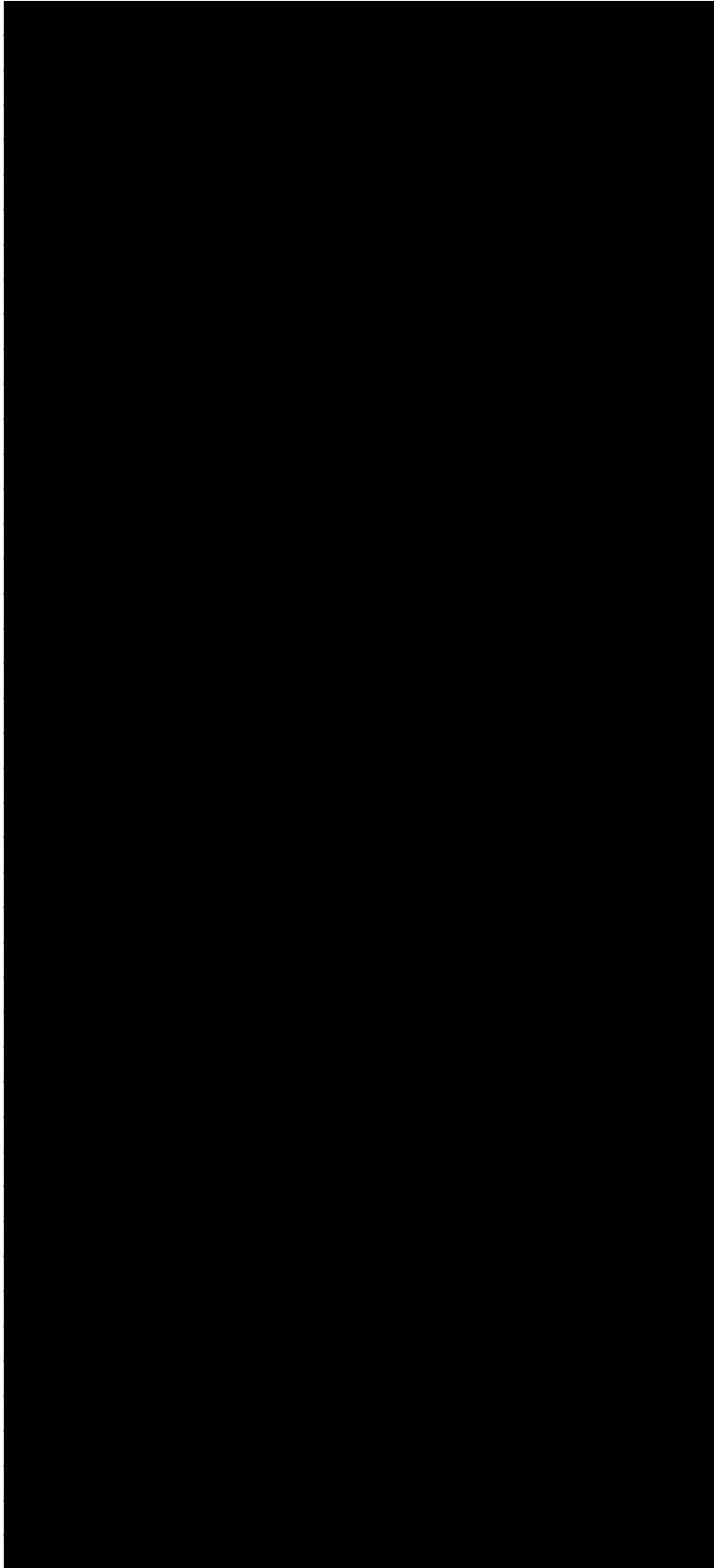
- (ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;



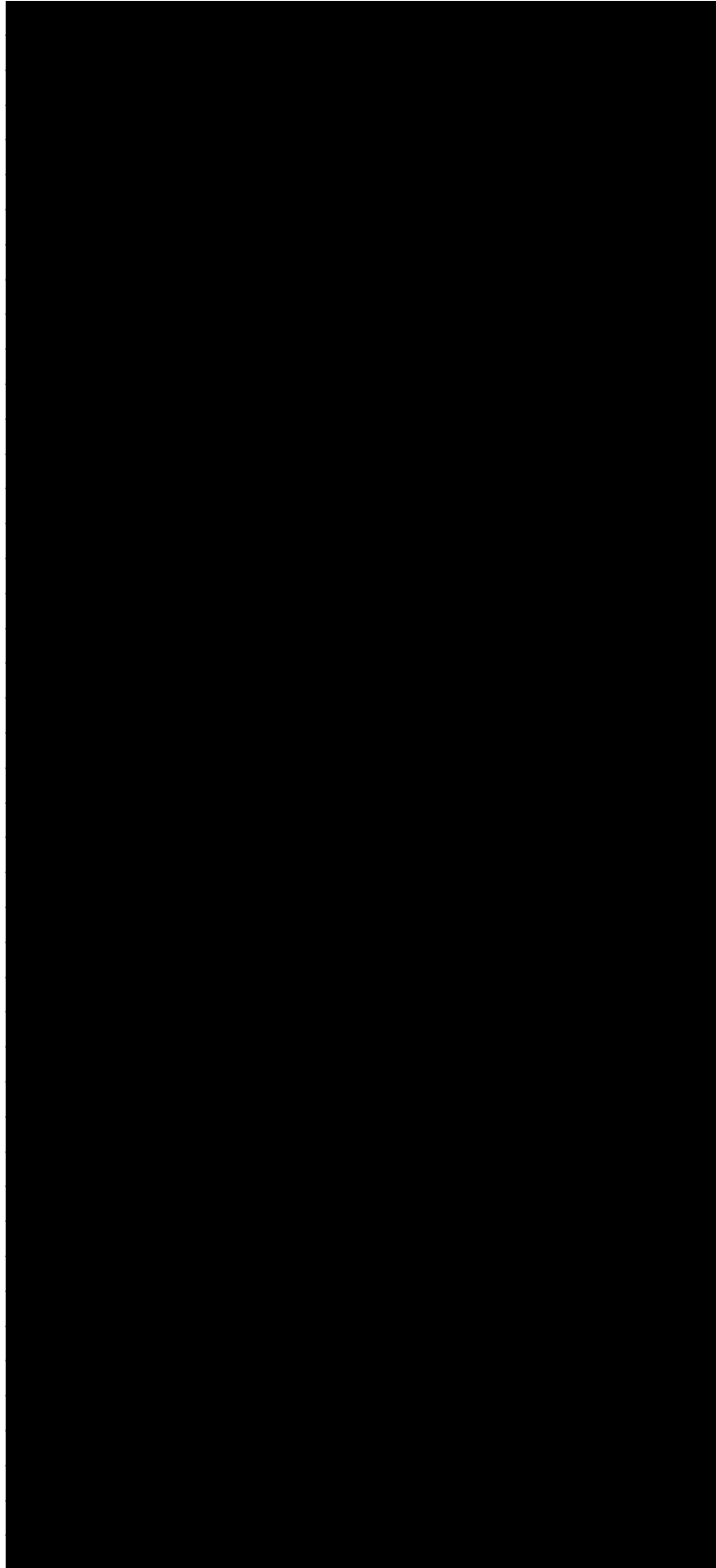
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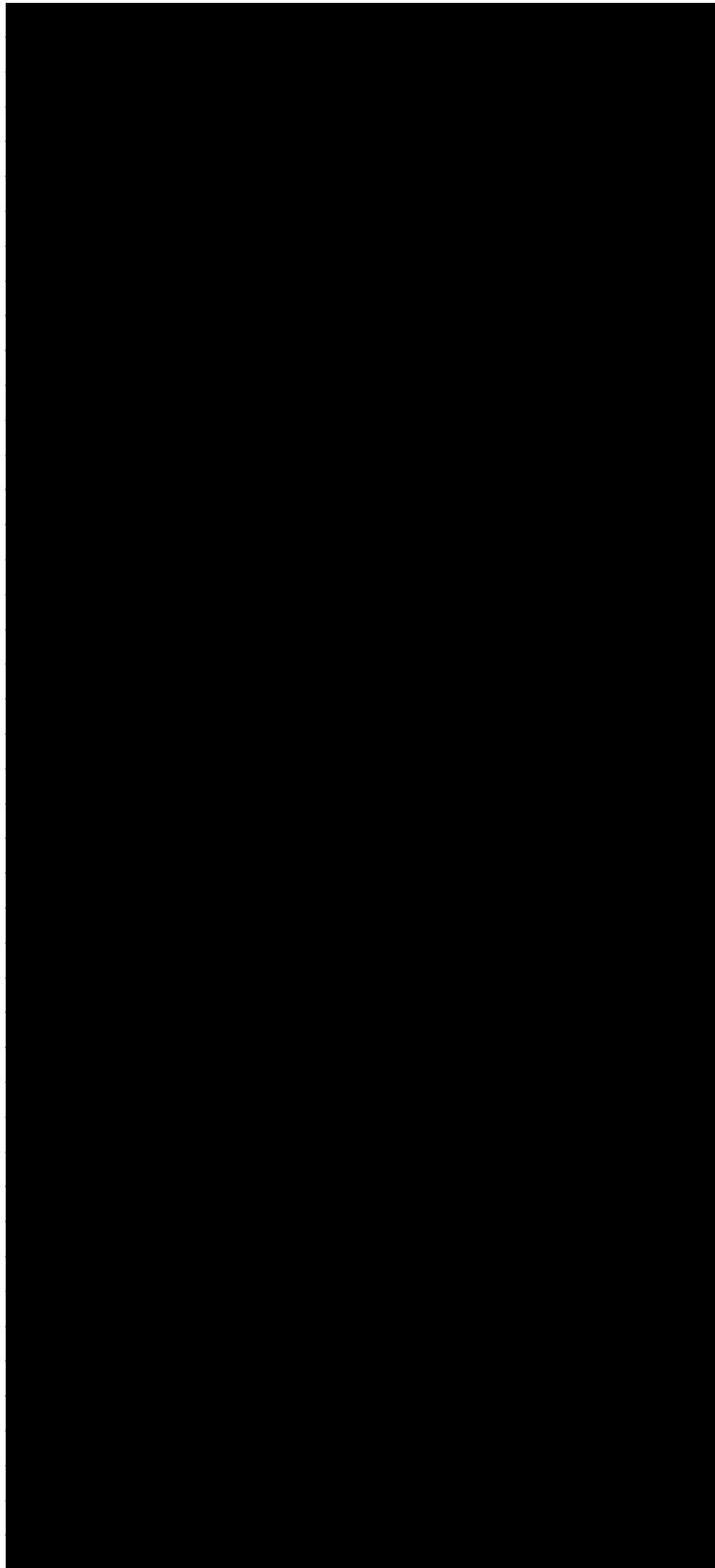
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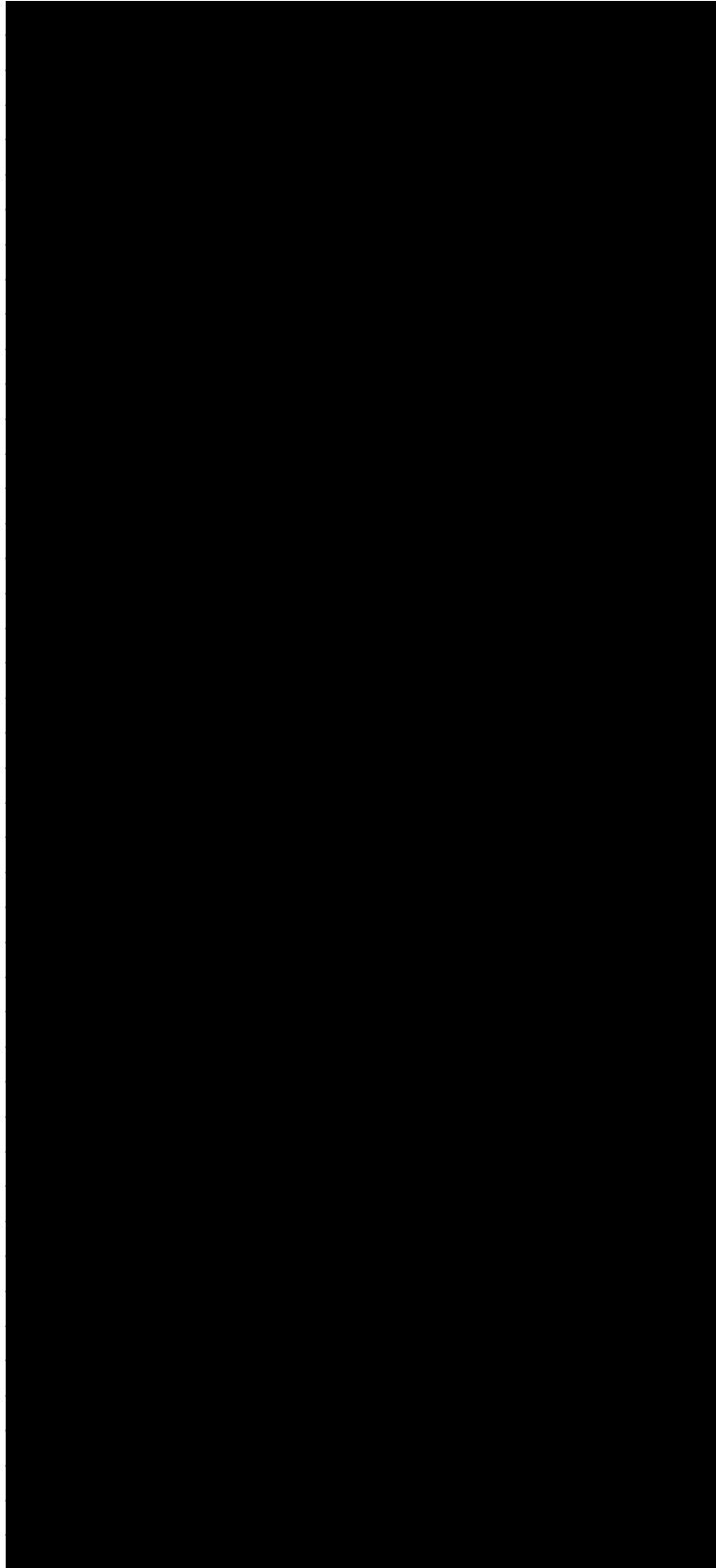
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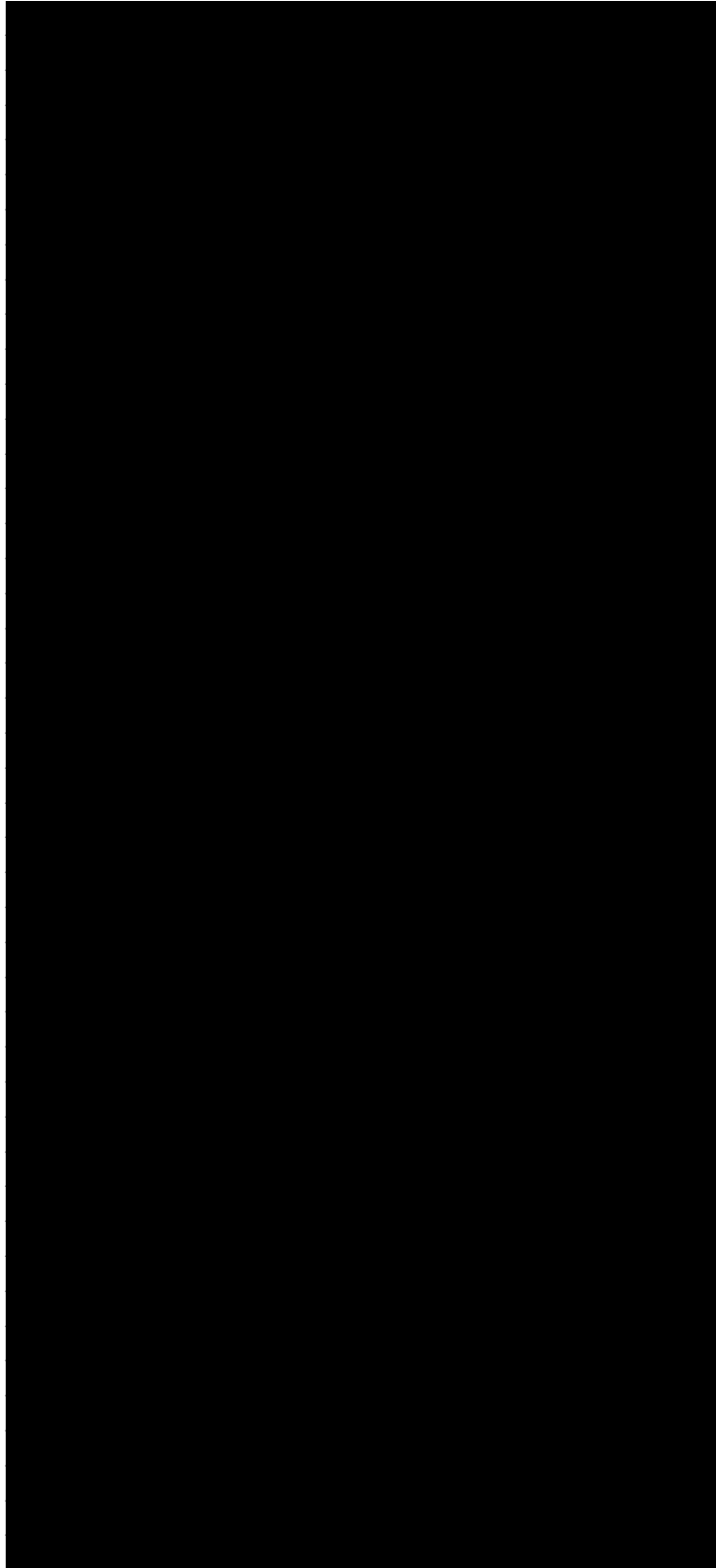
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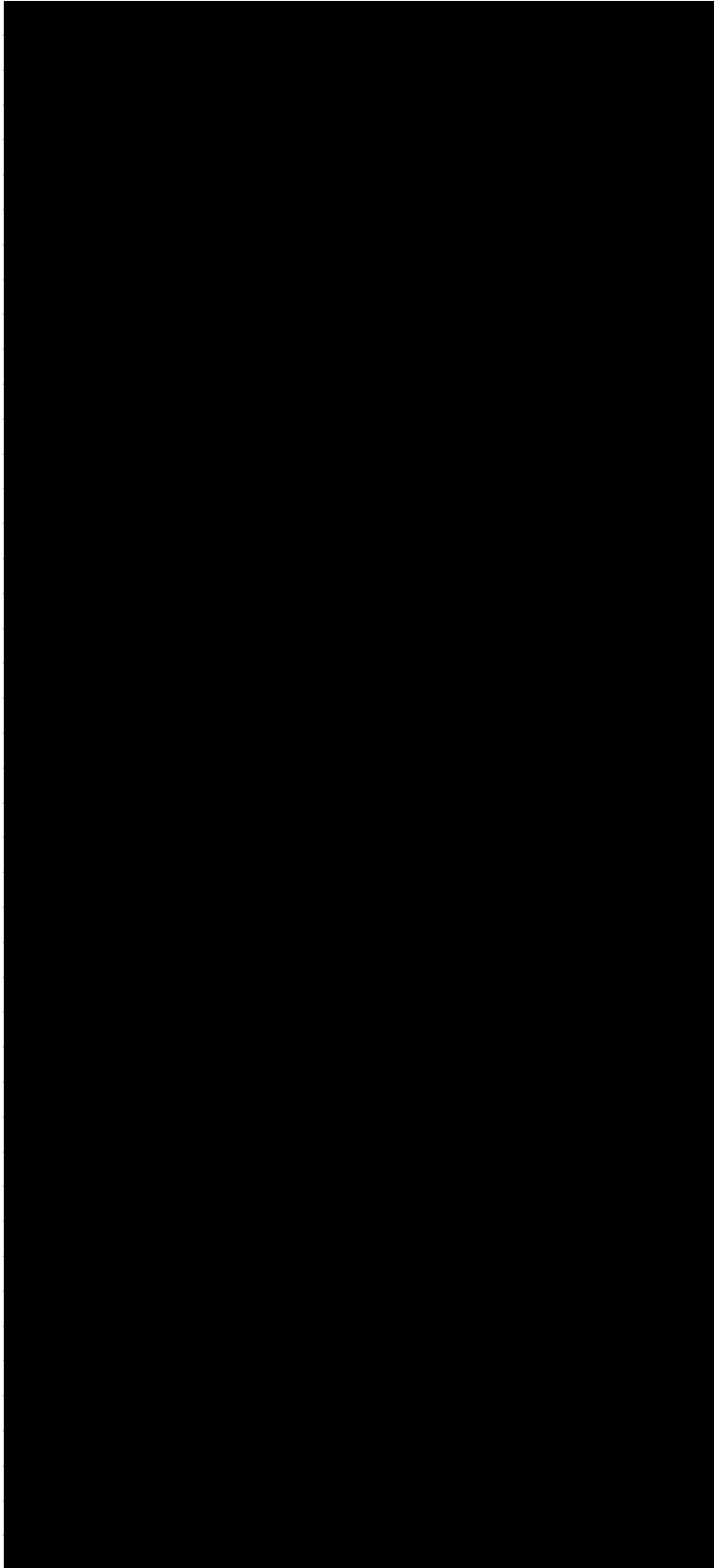
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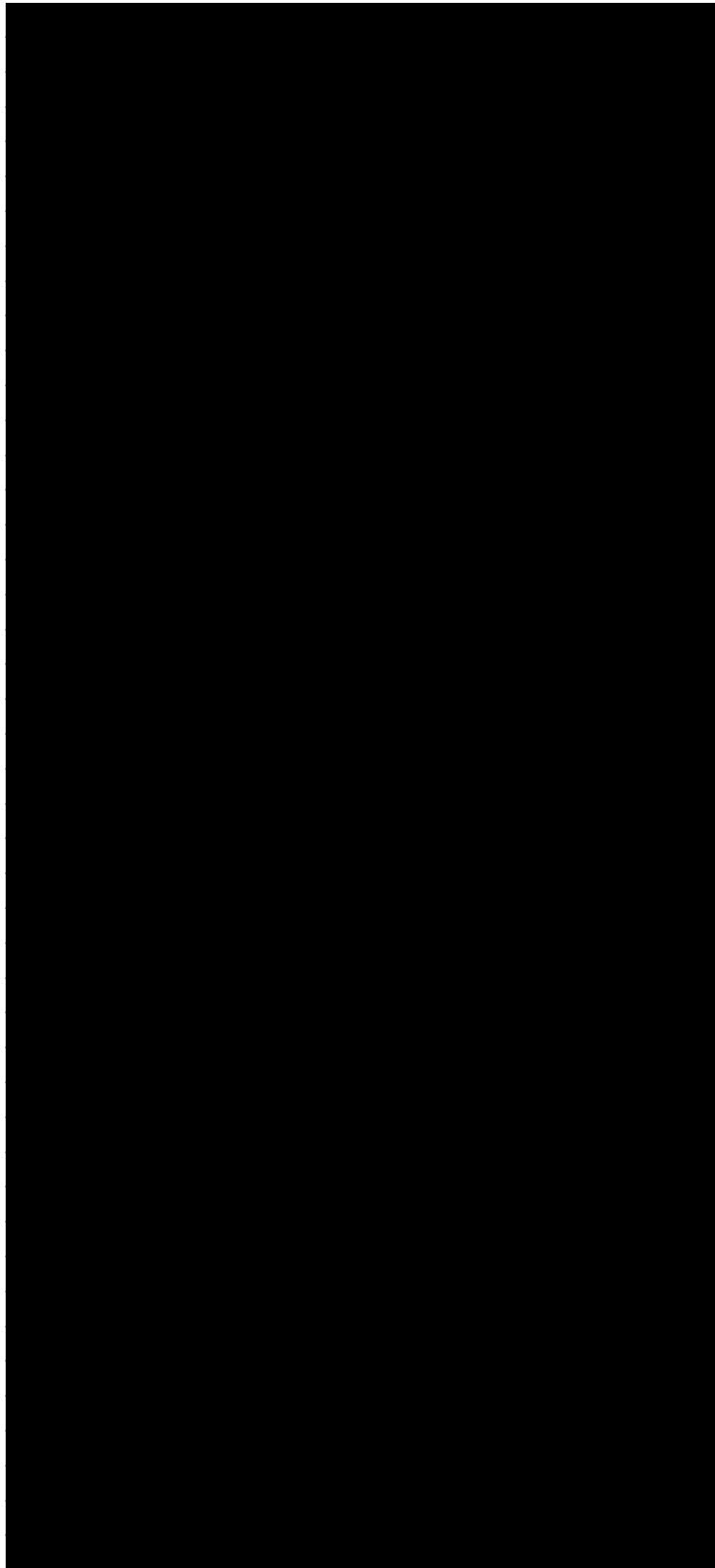


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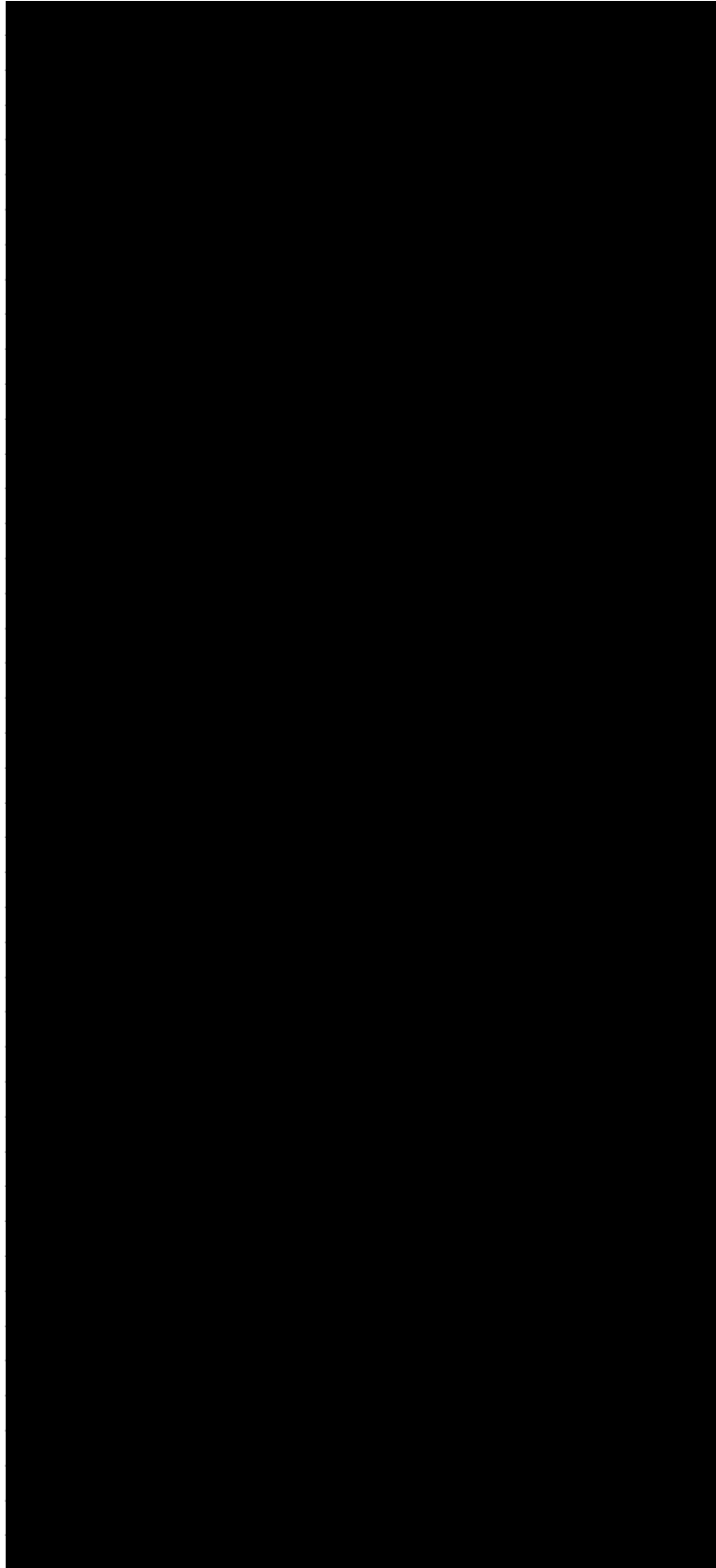


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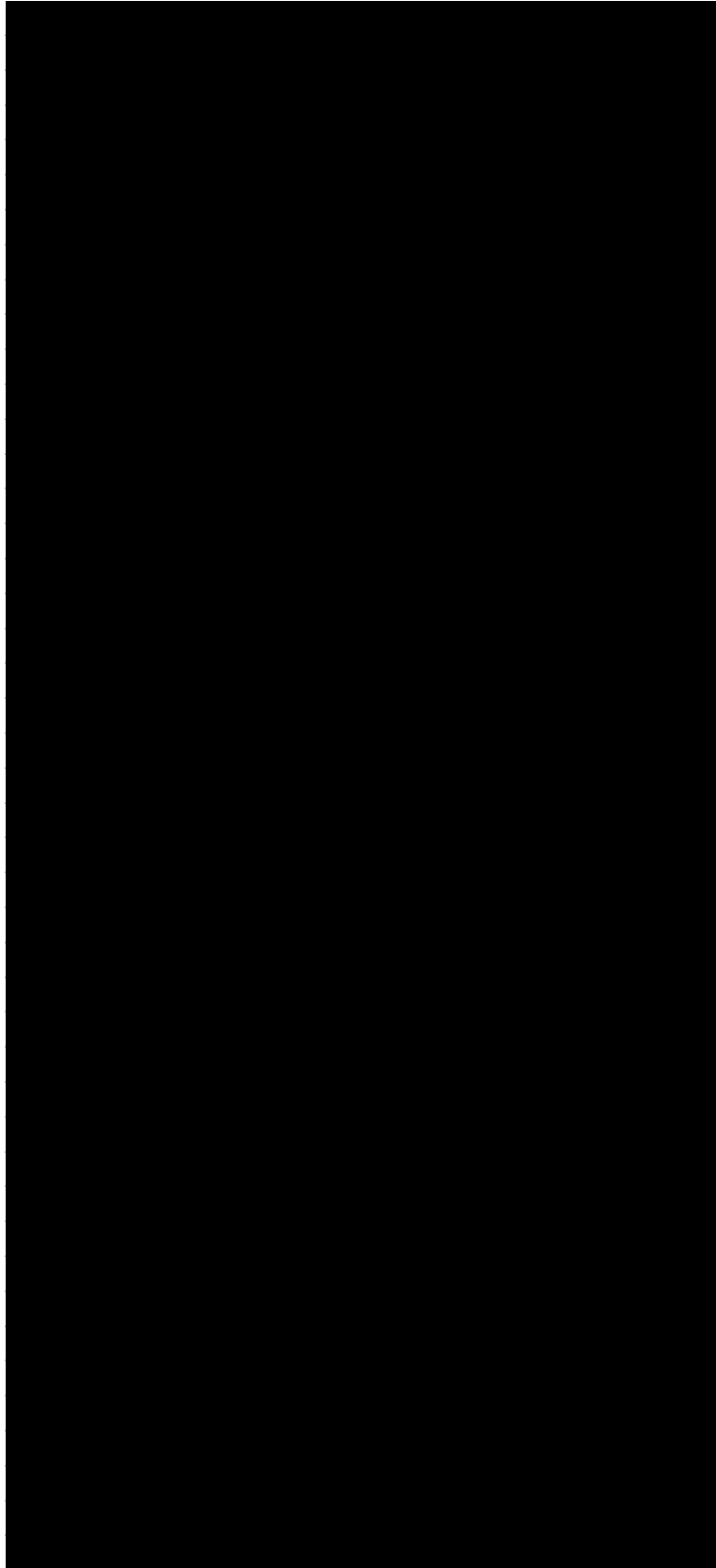




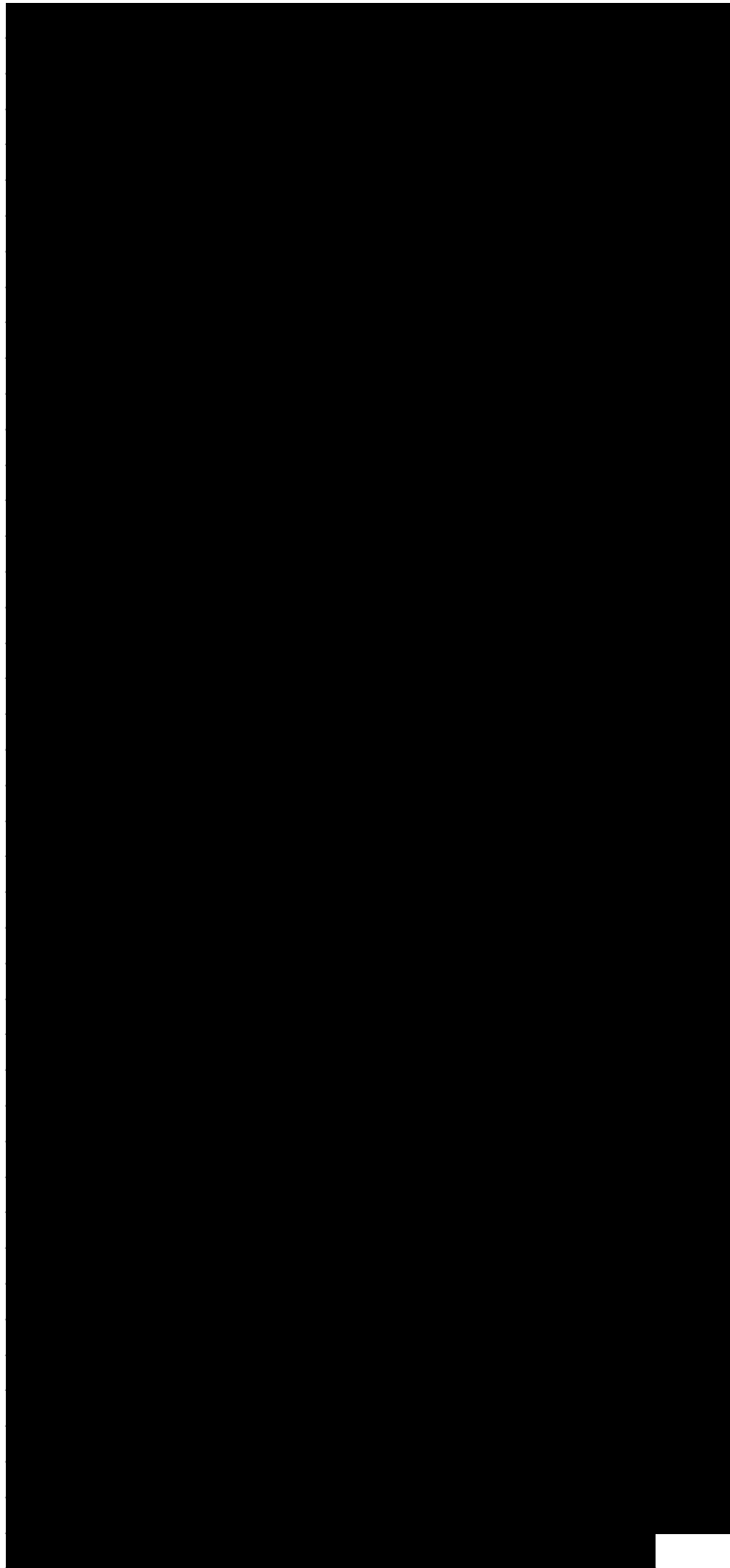
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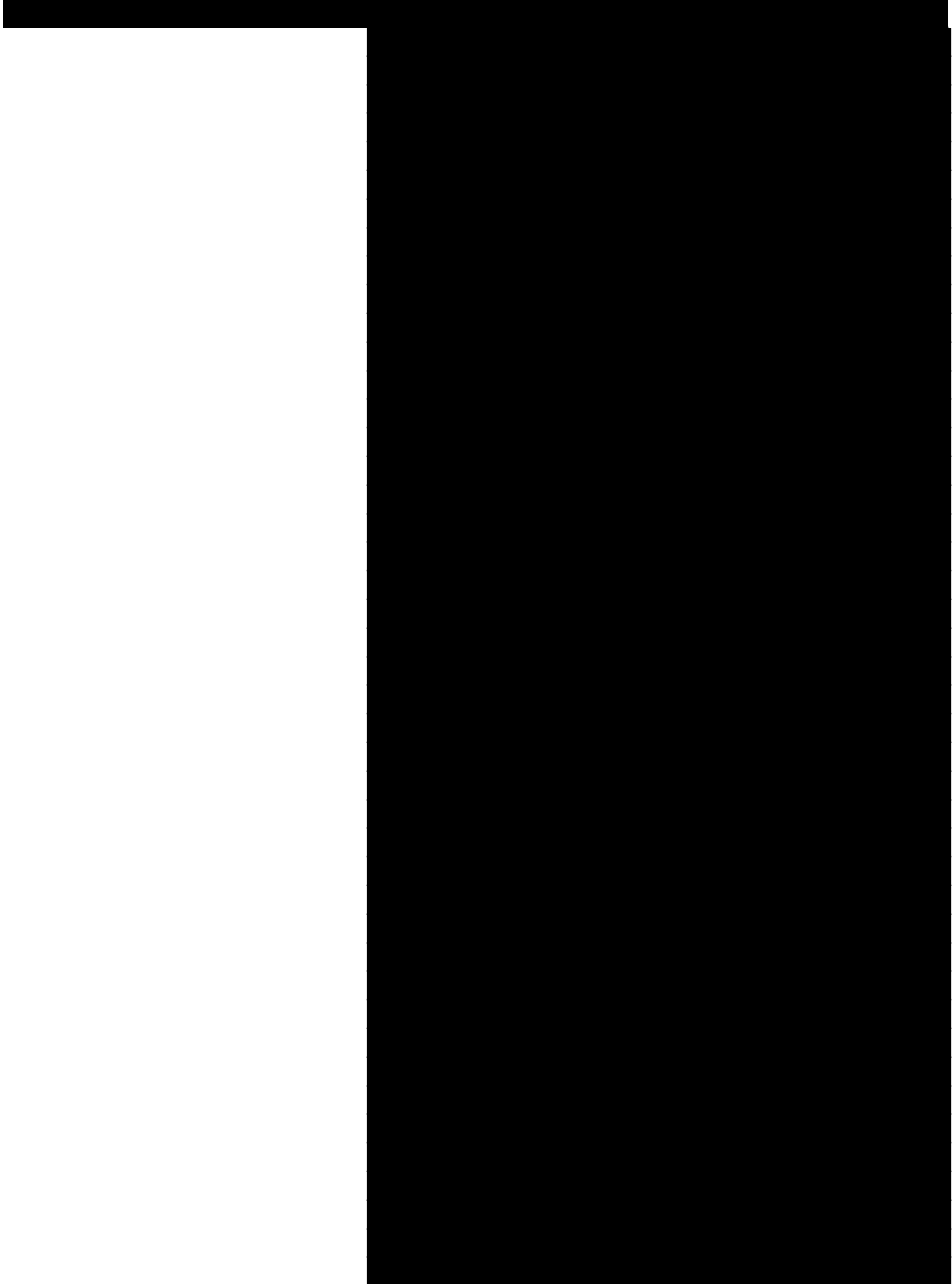
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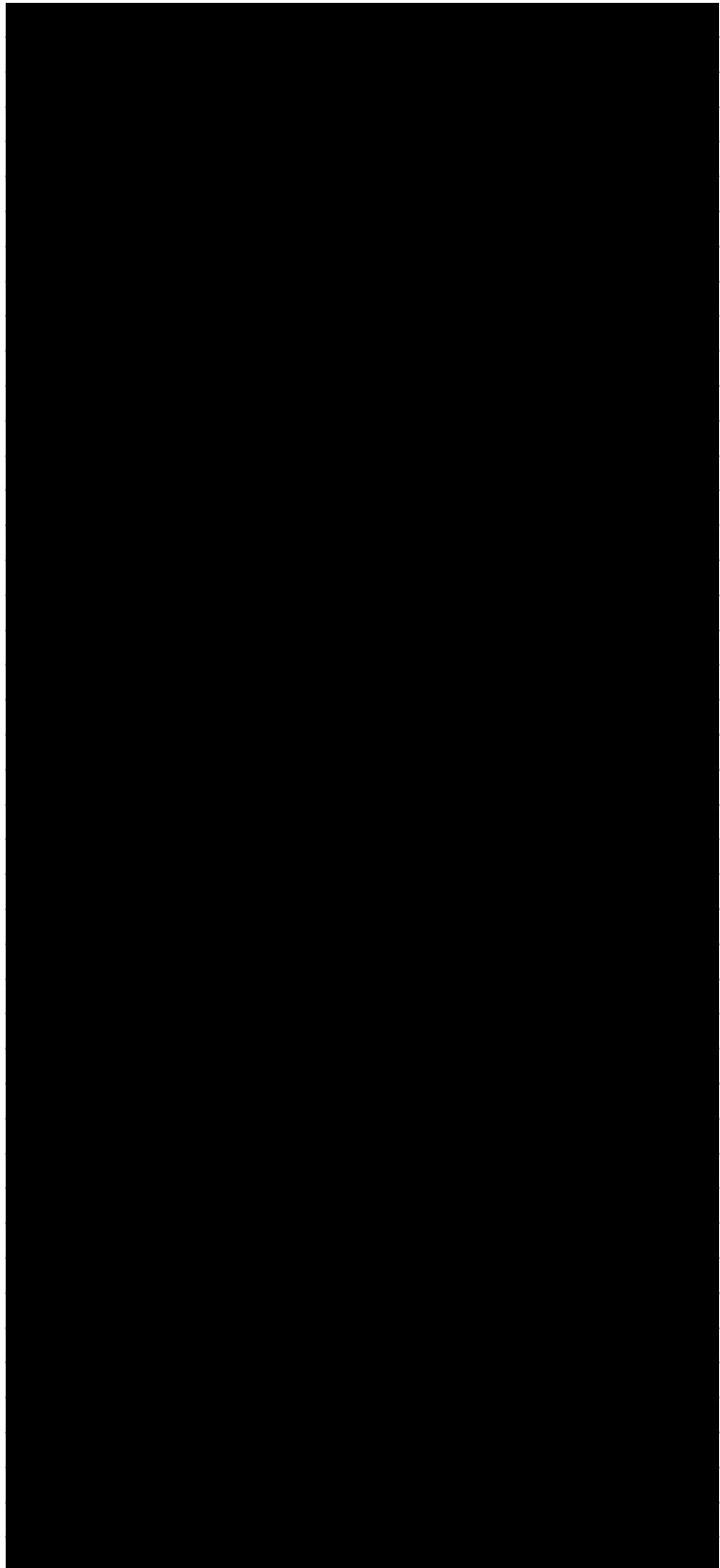




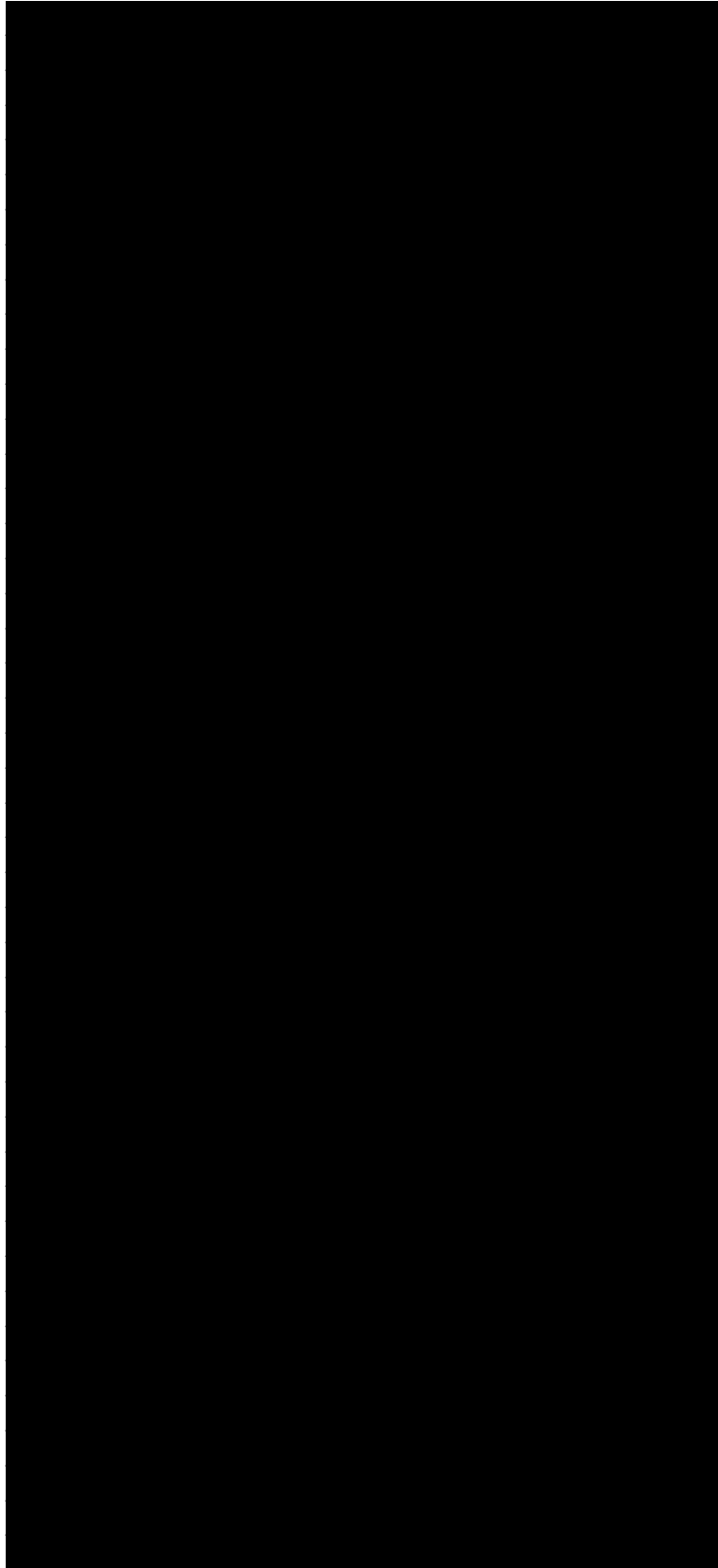




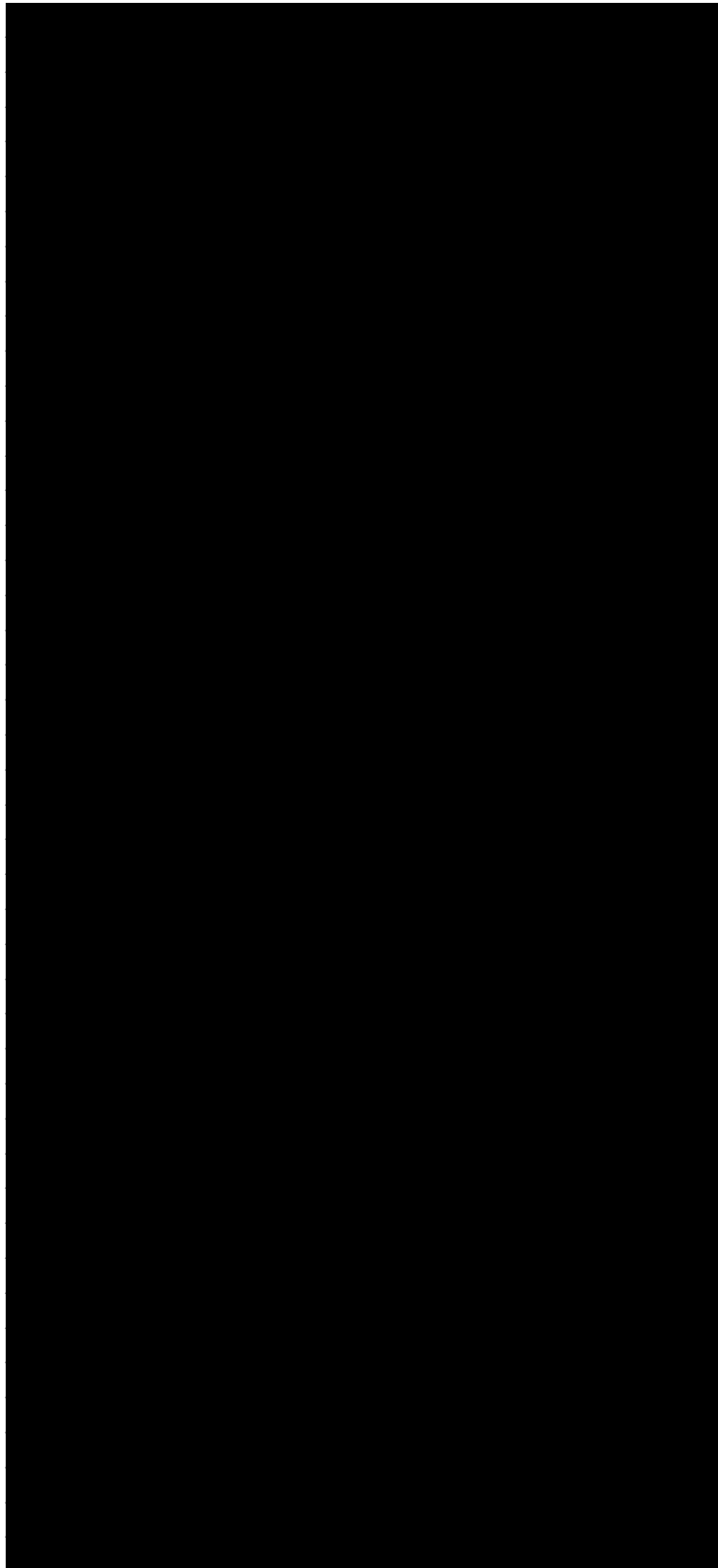
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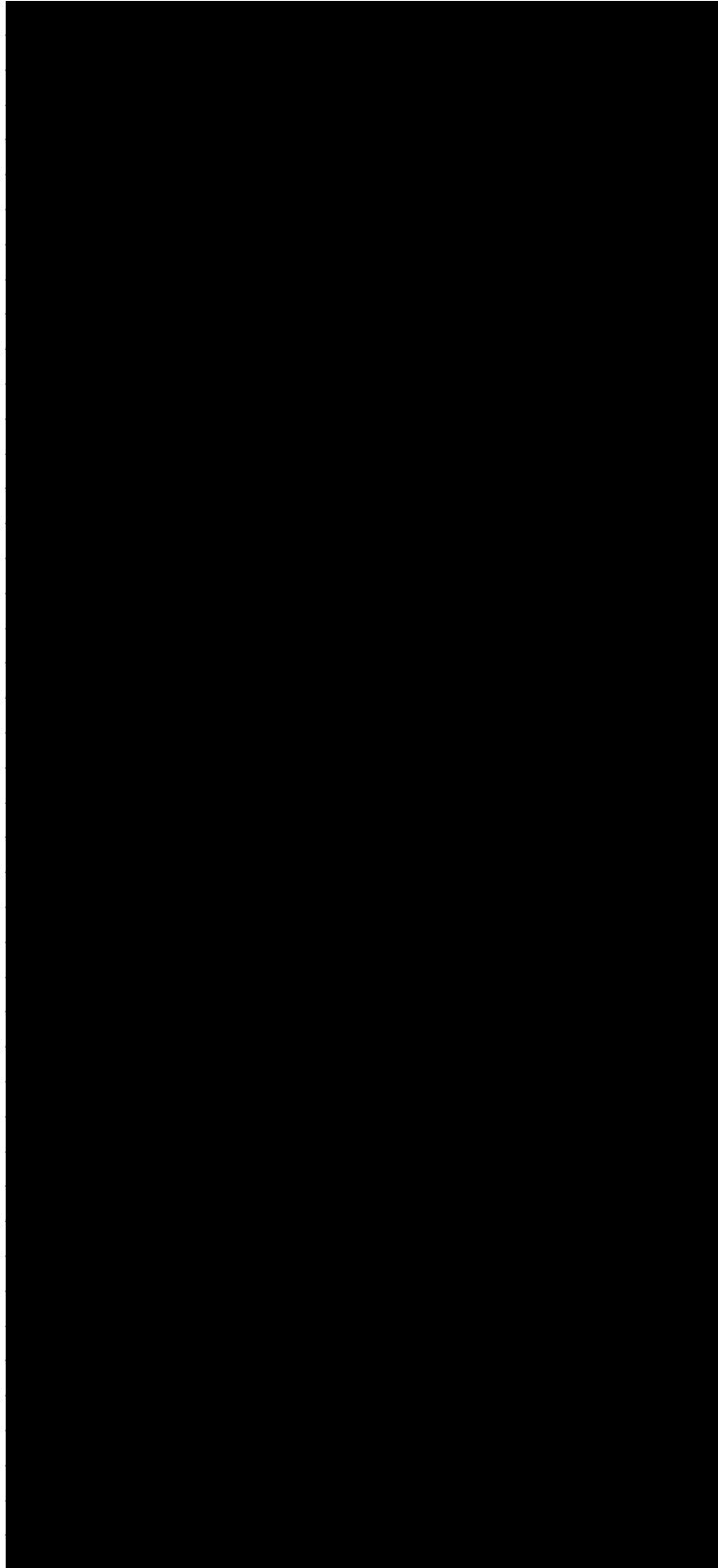
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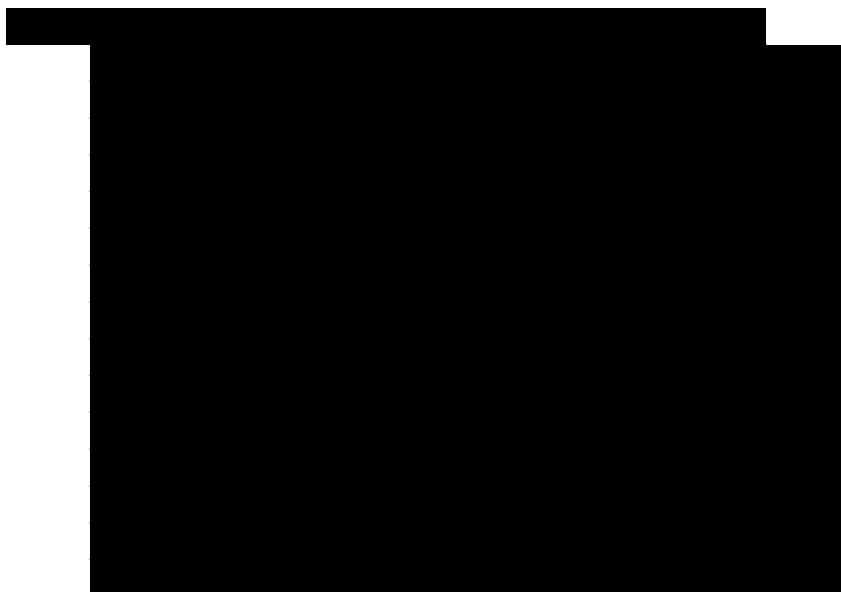
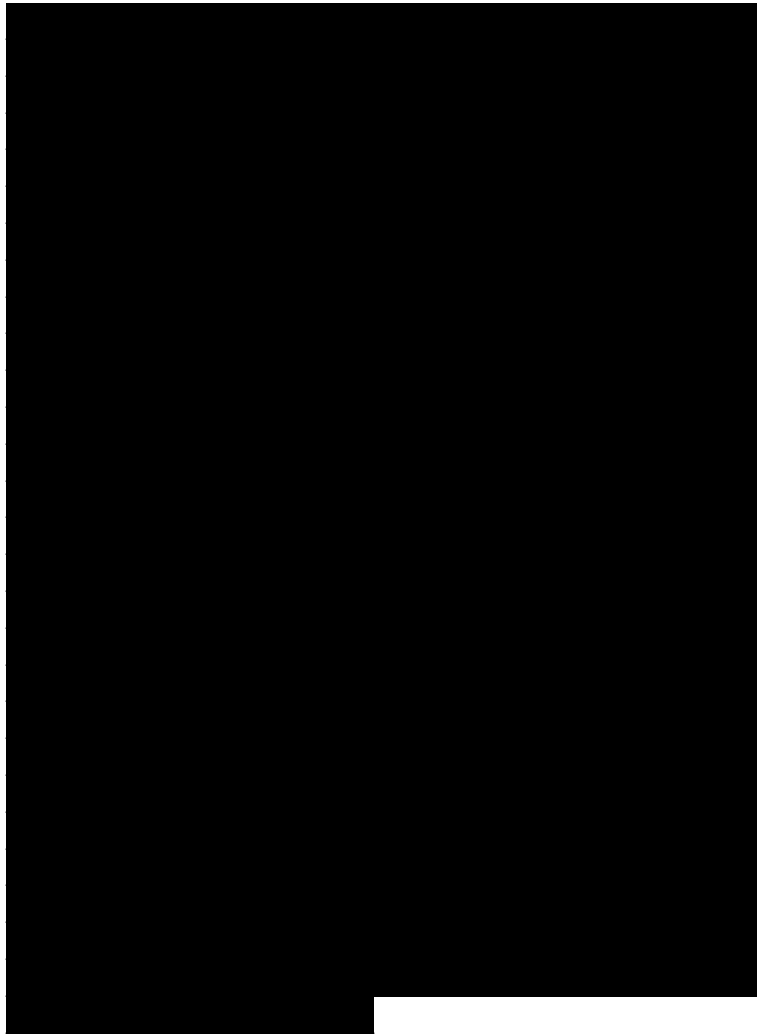
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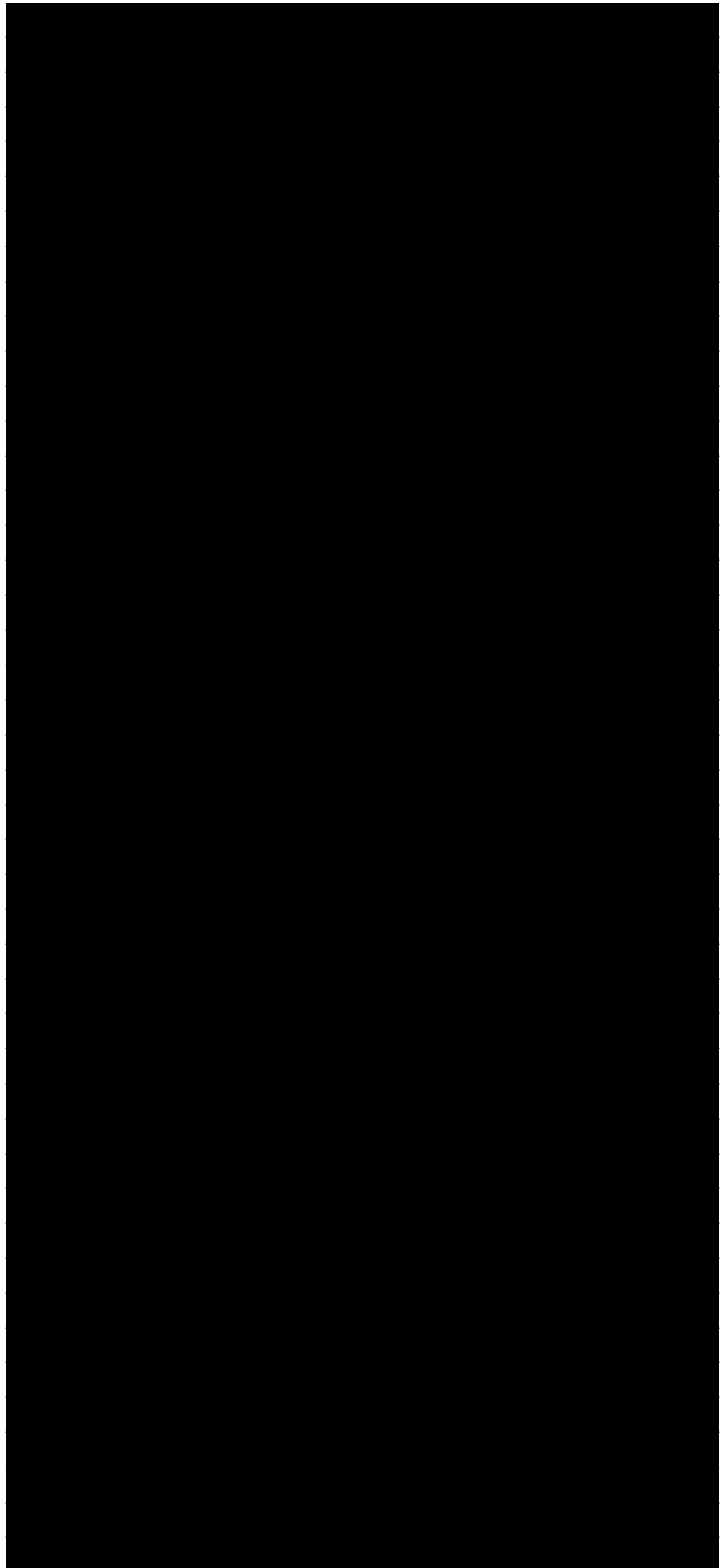




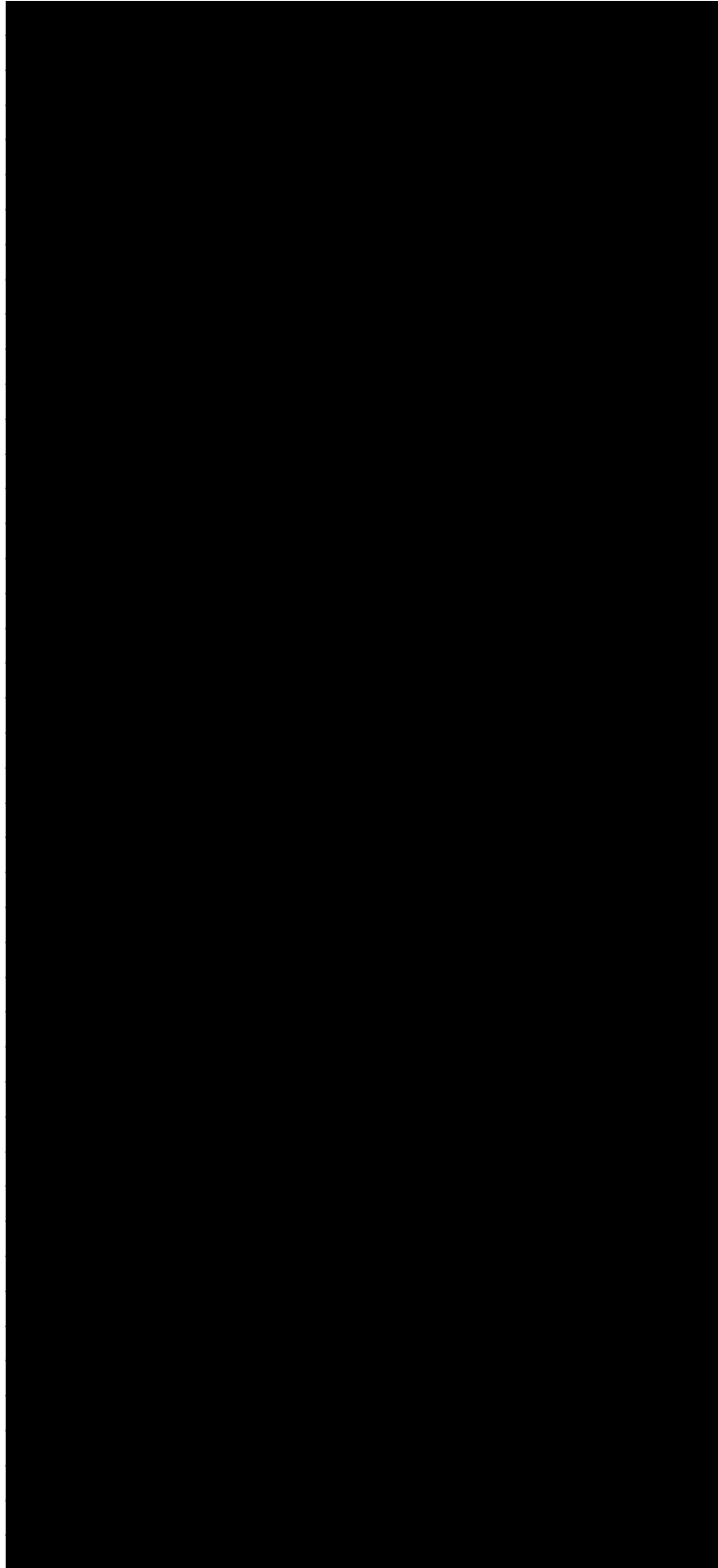




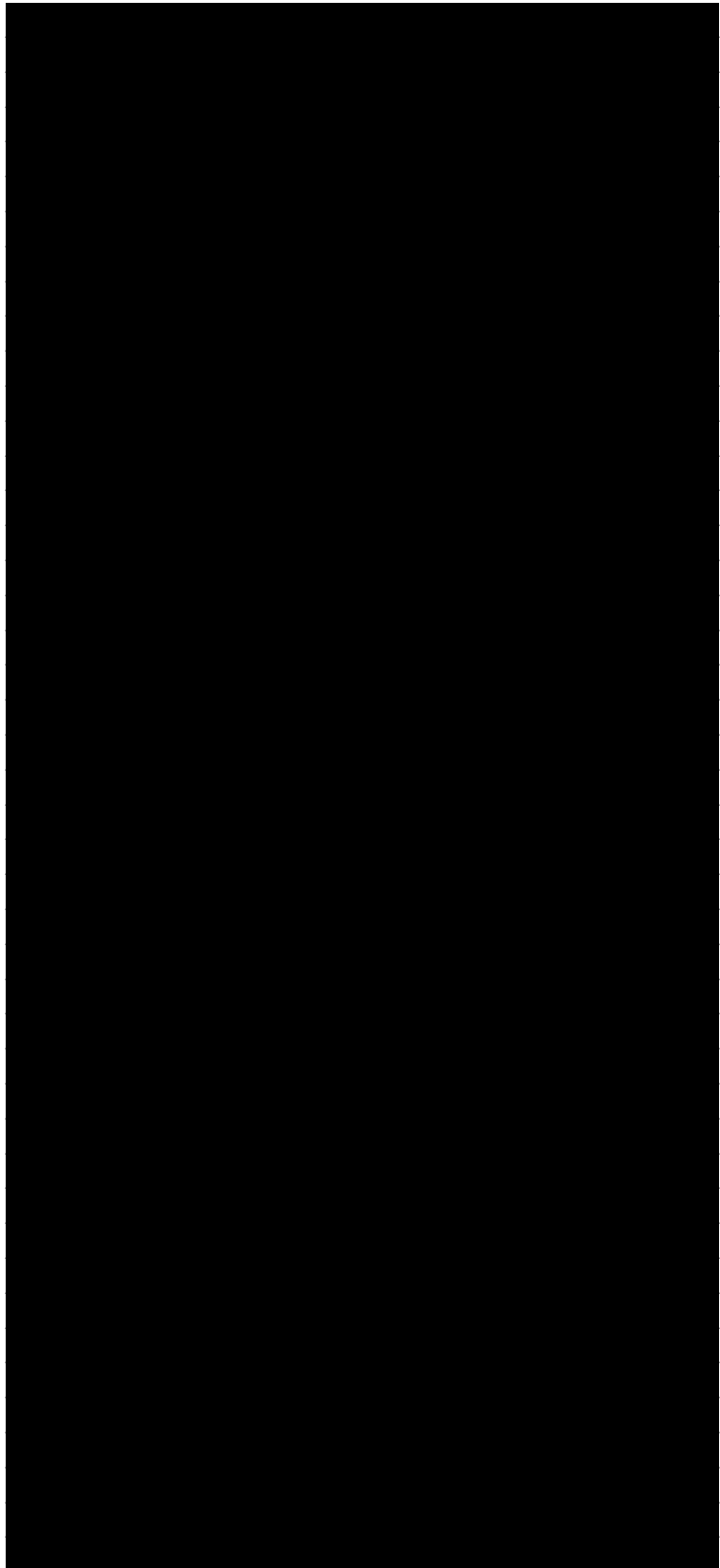
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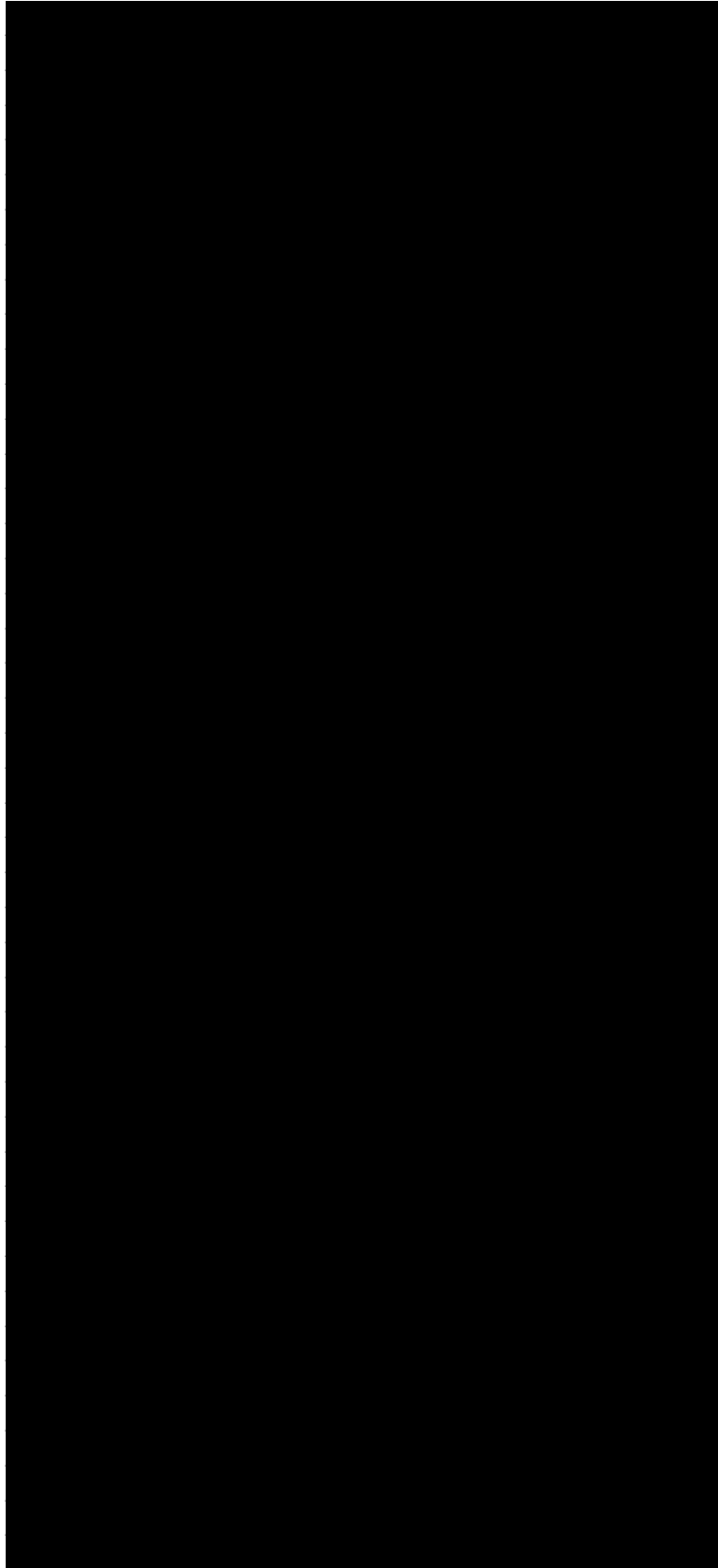
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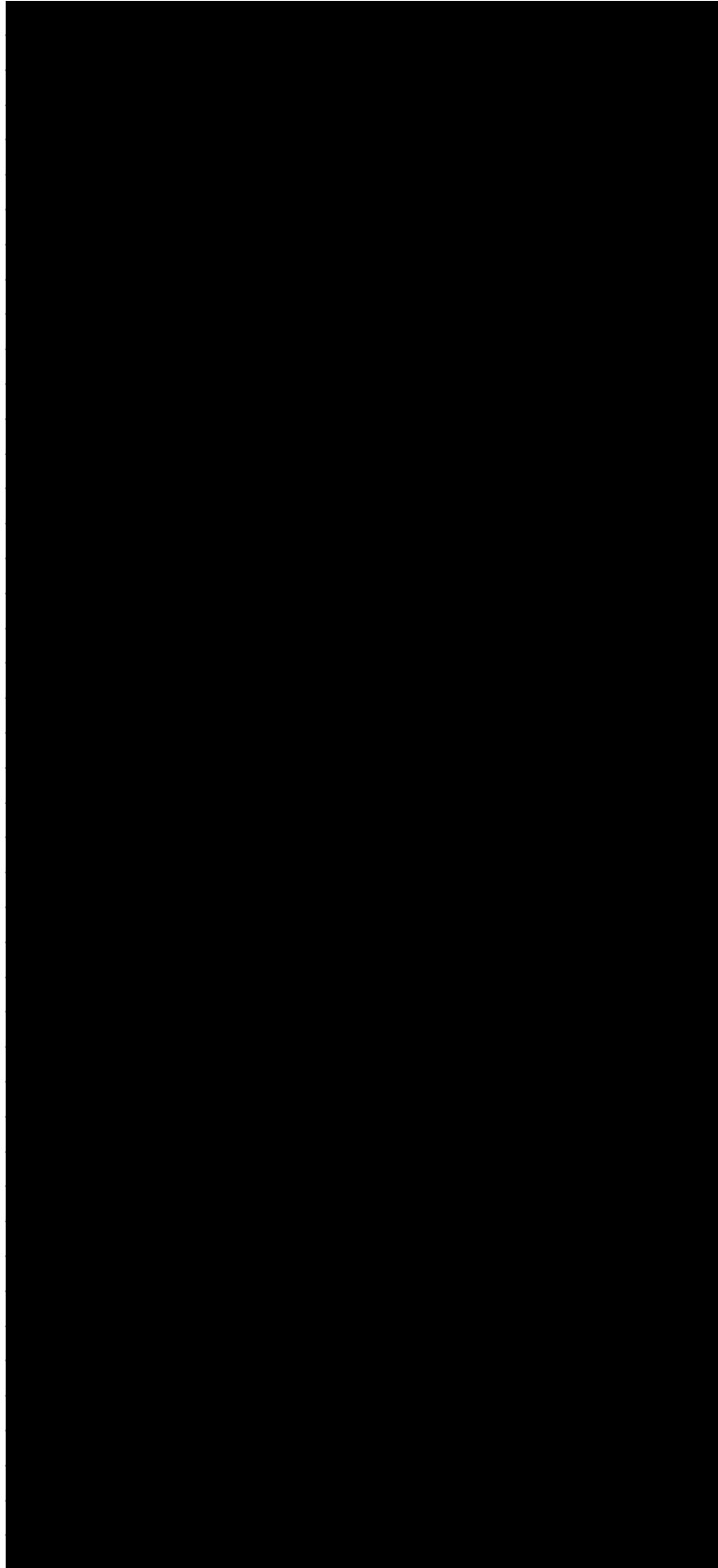
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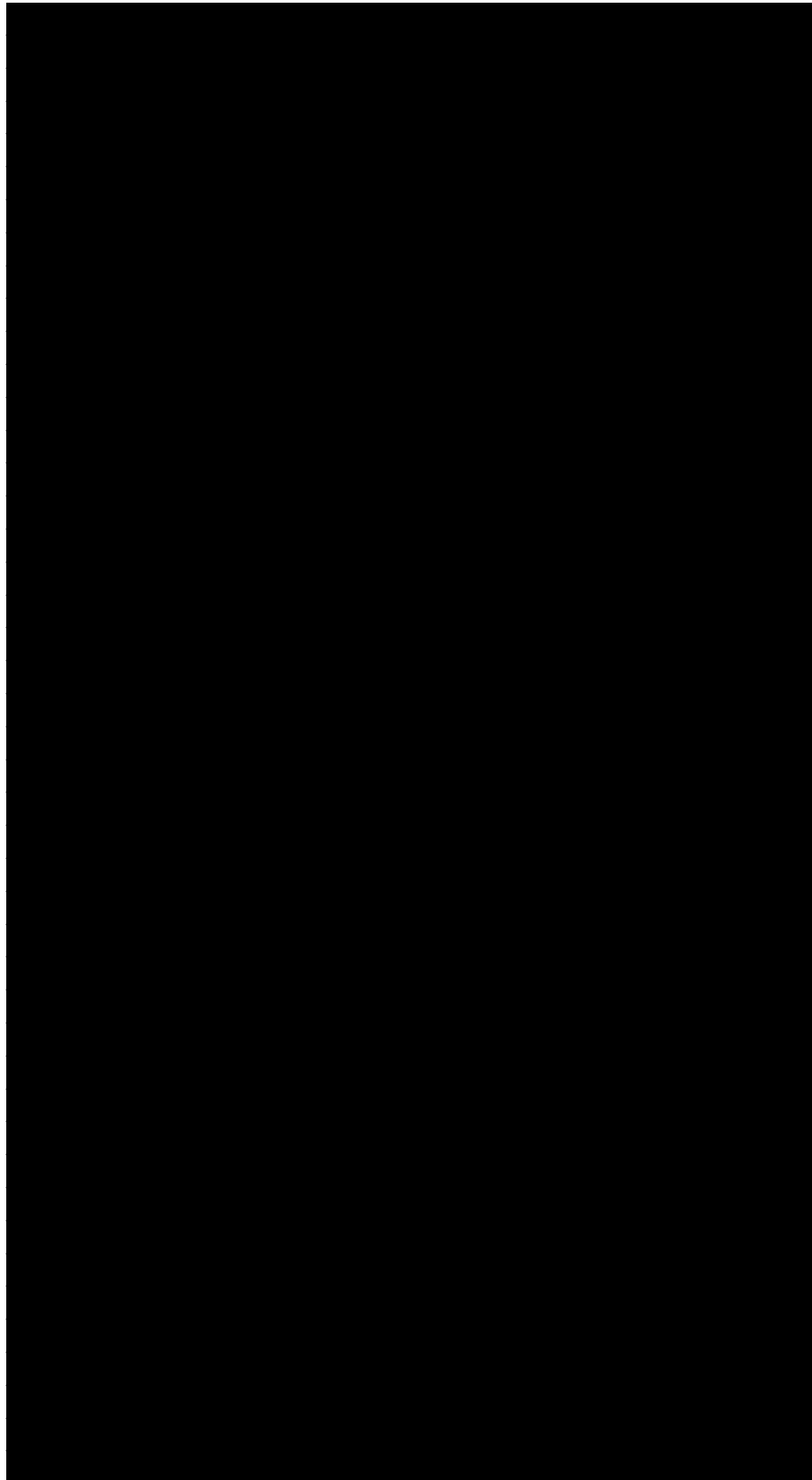
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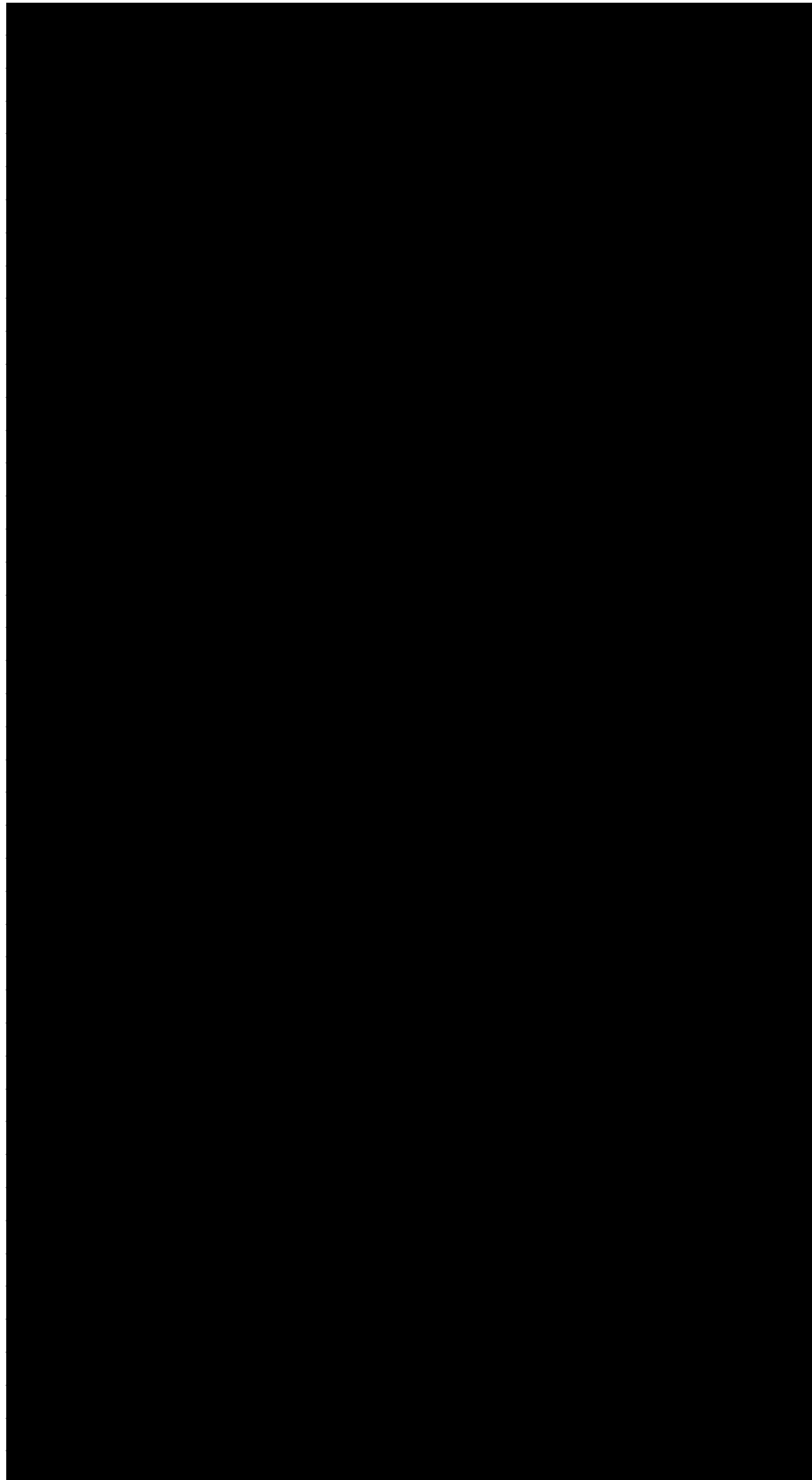
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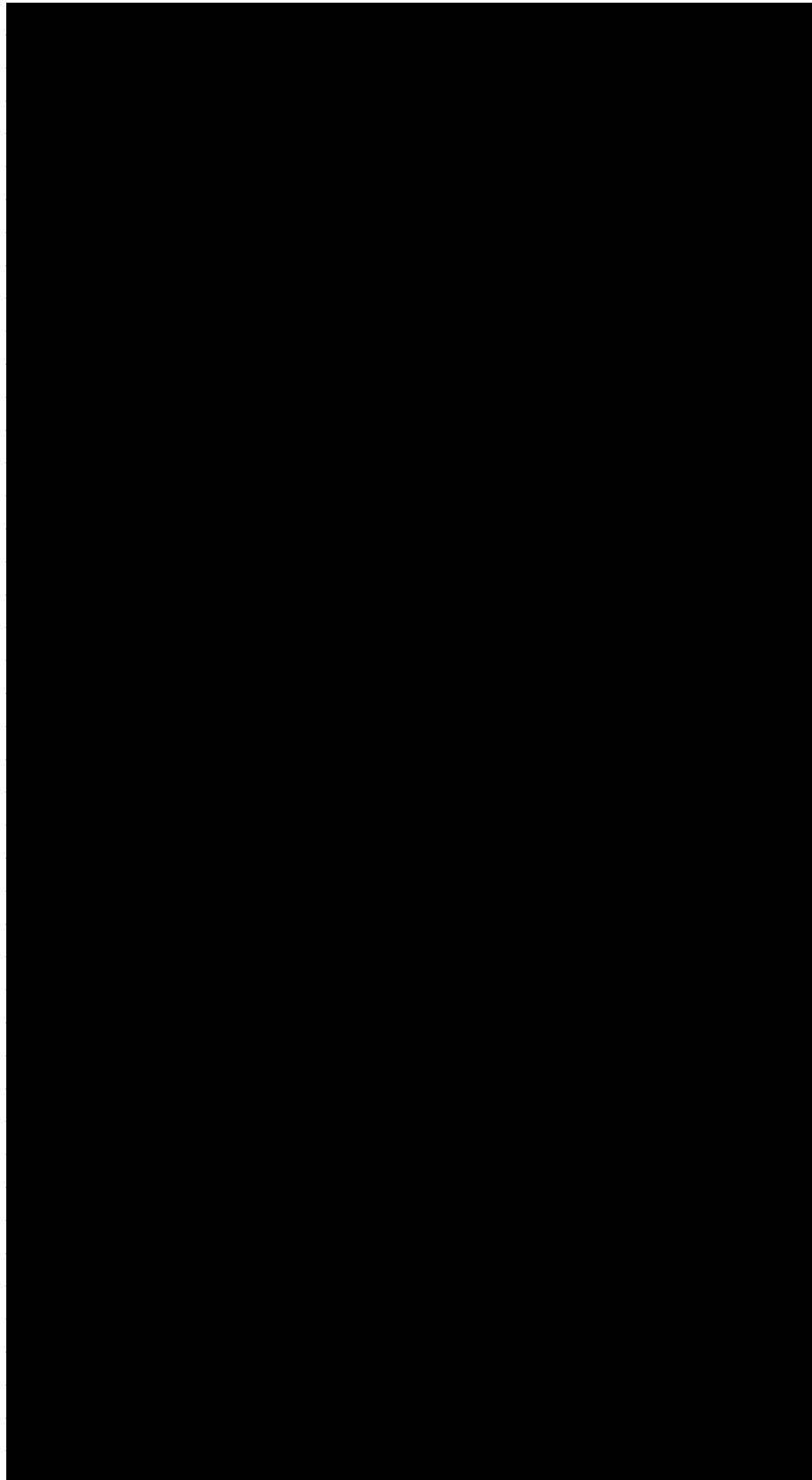
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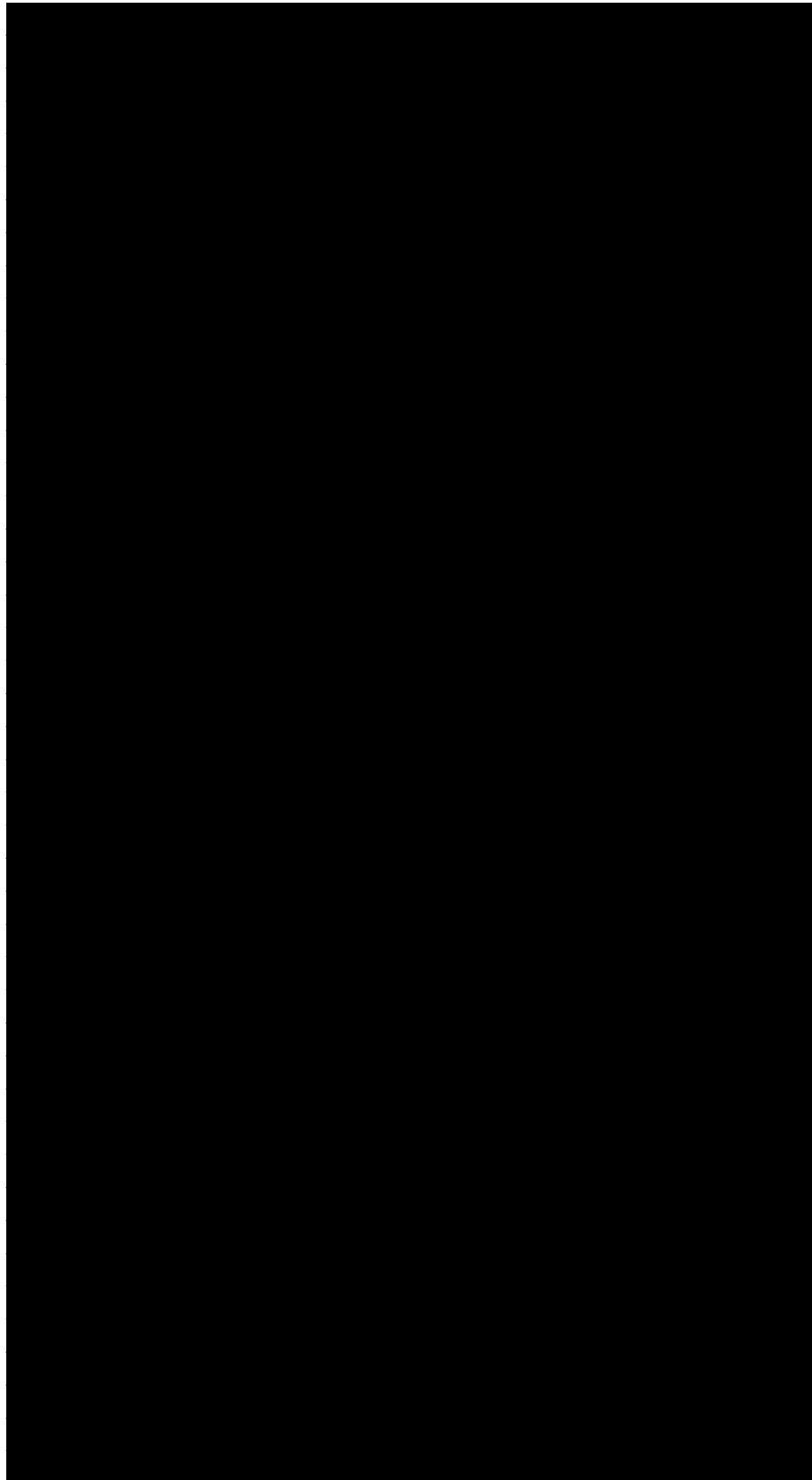
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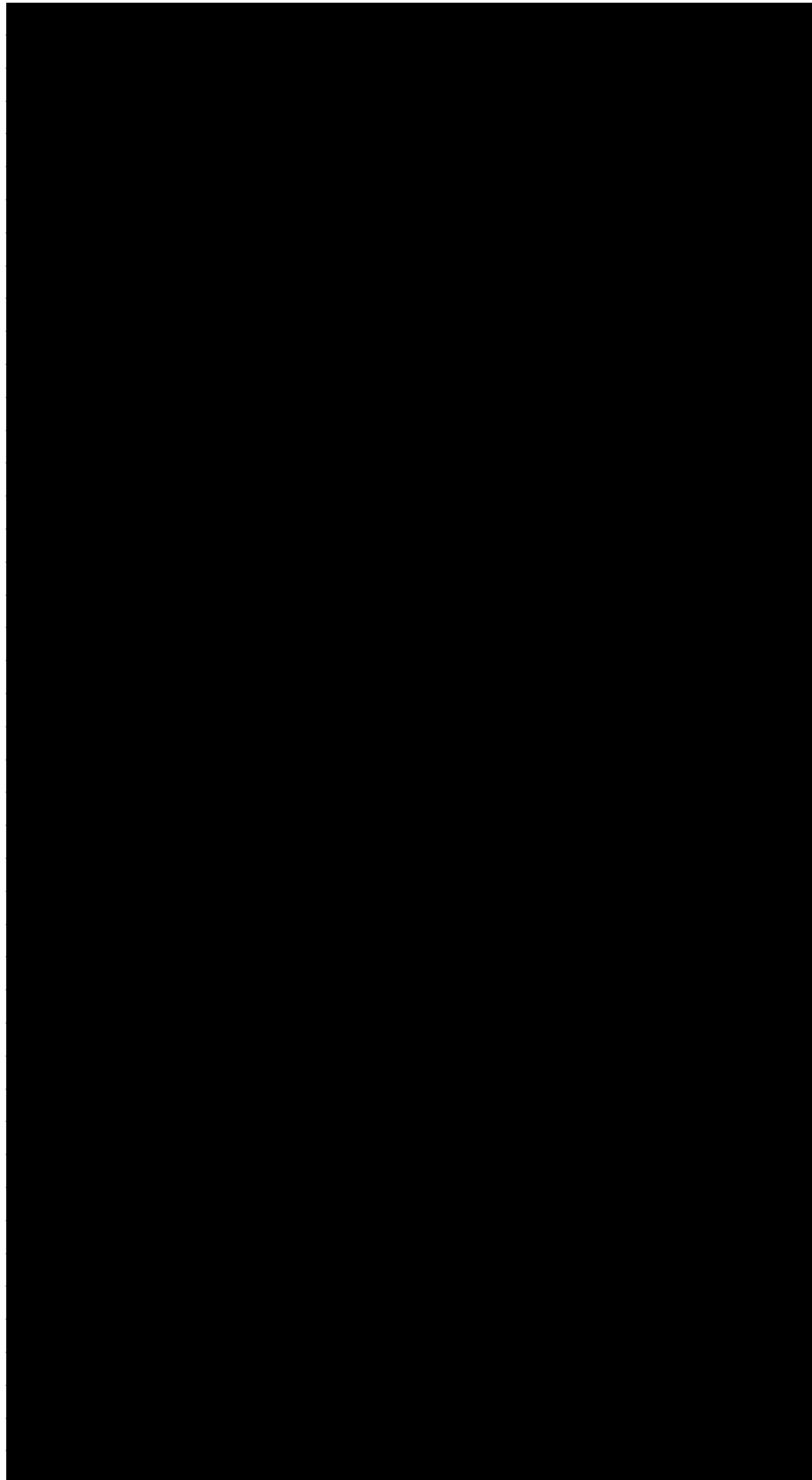
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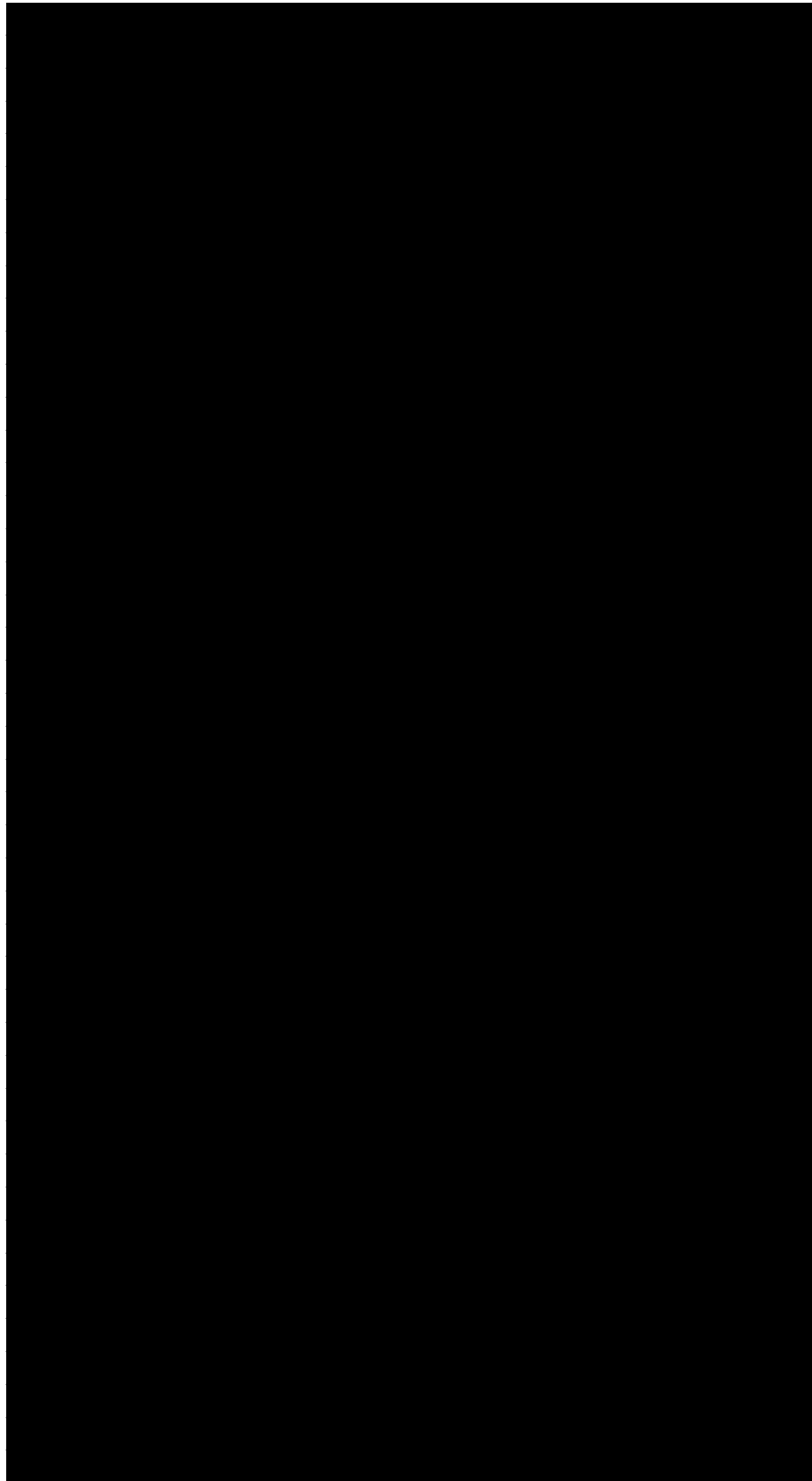
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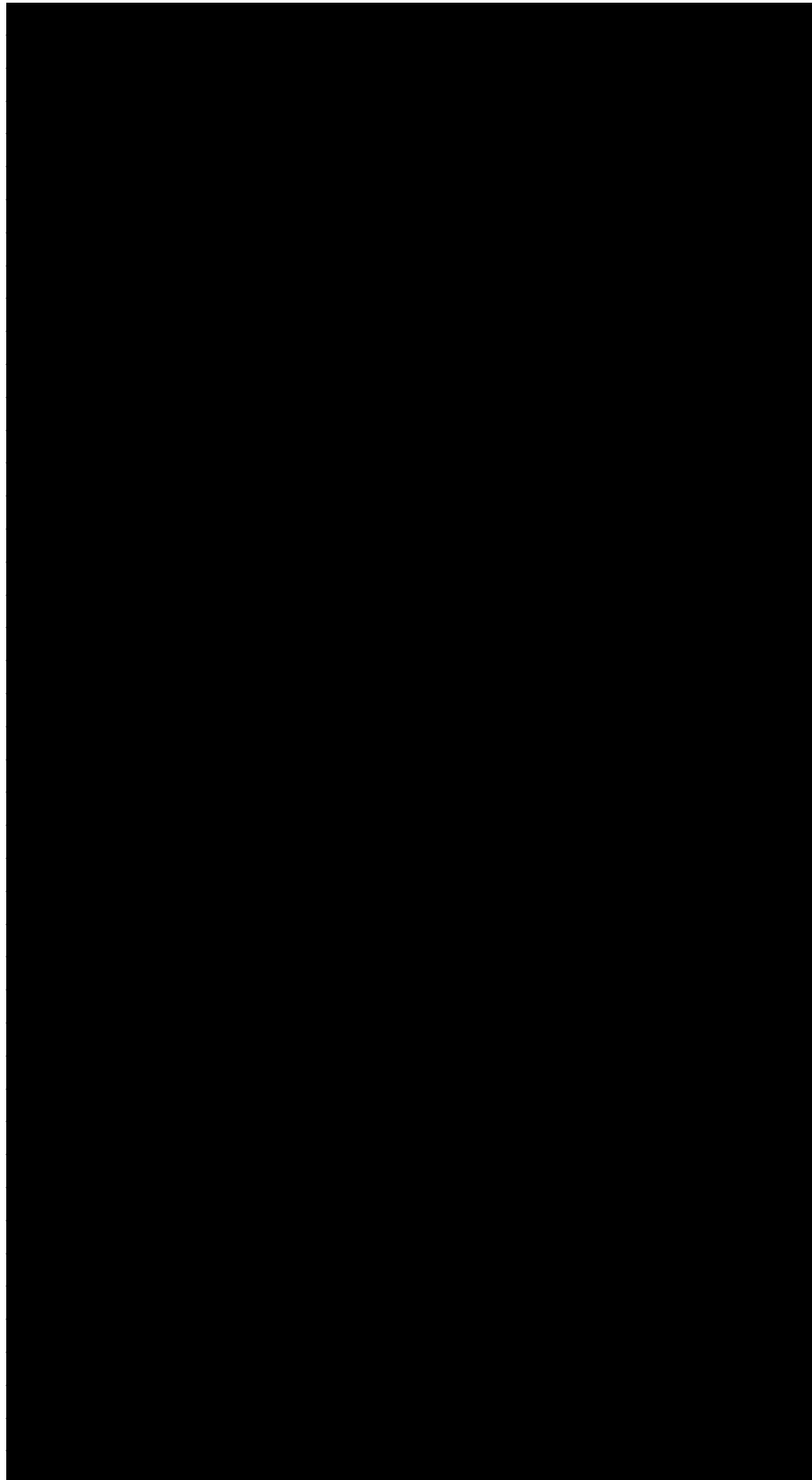
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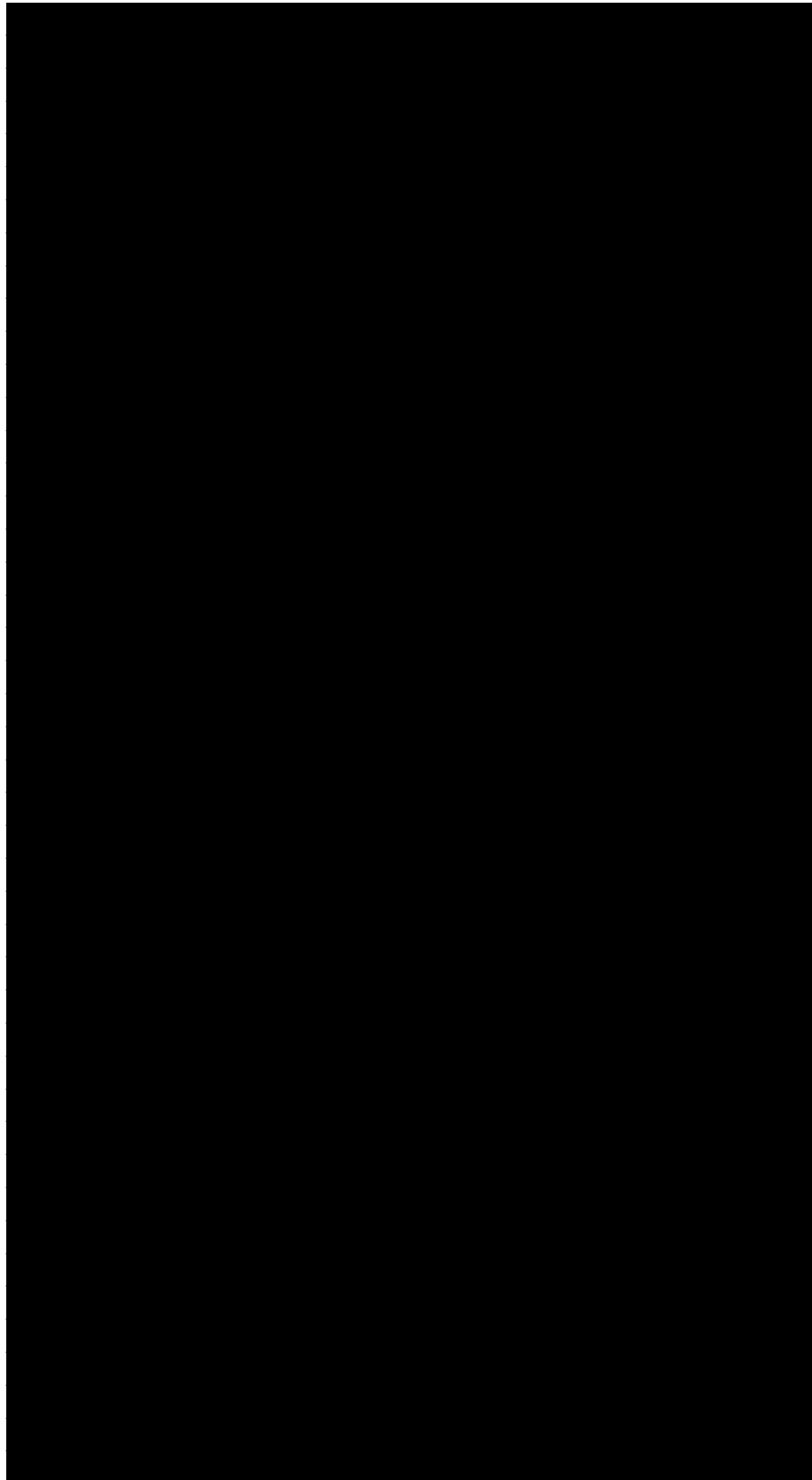
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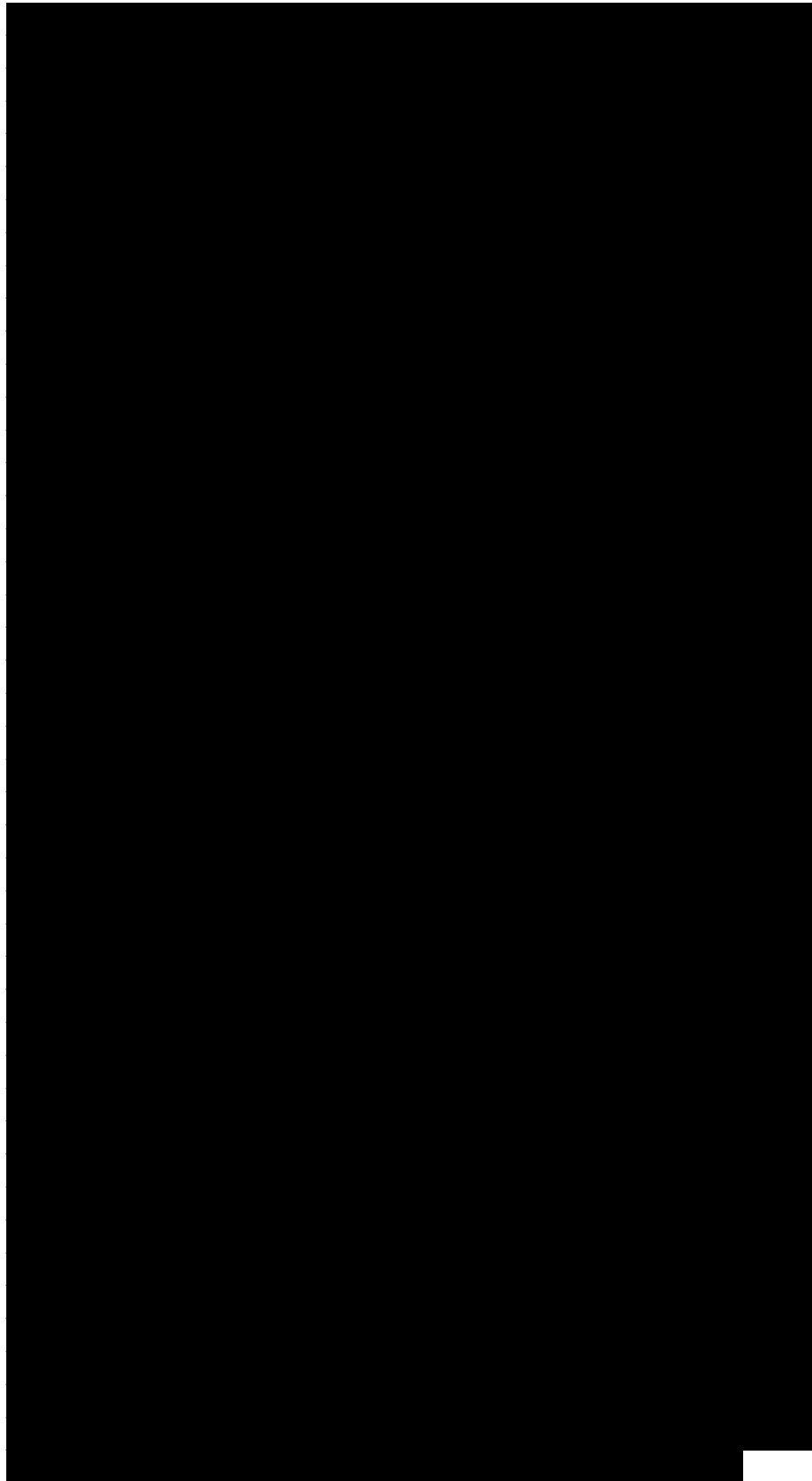
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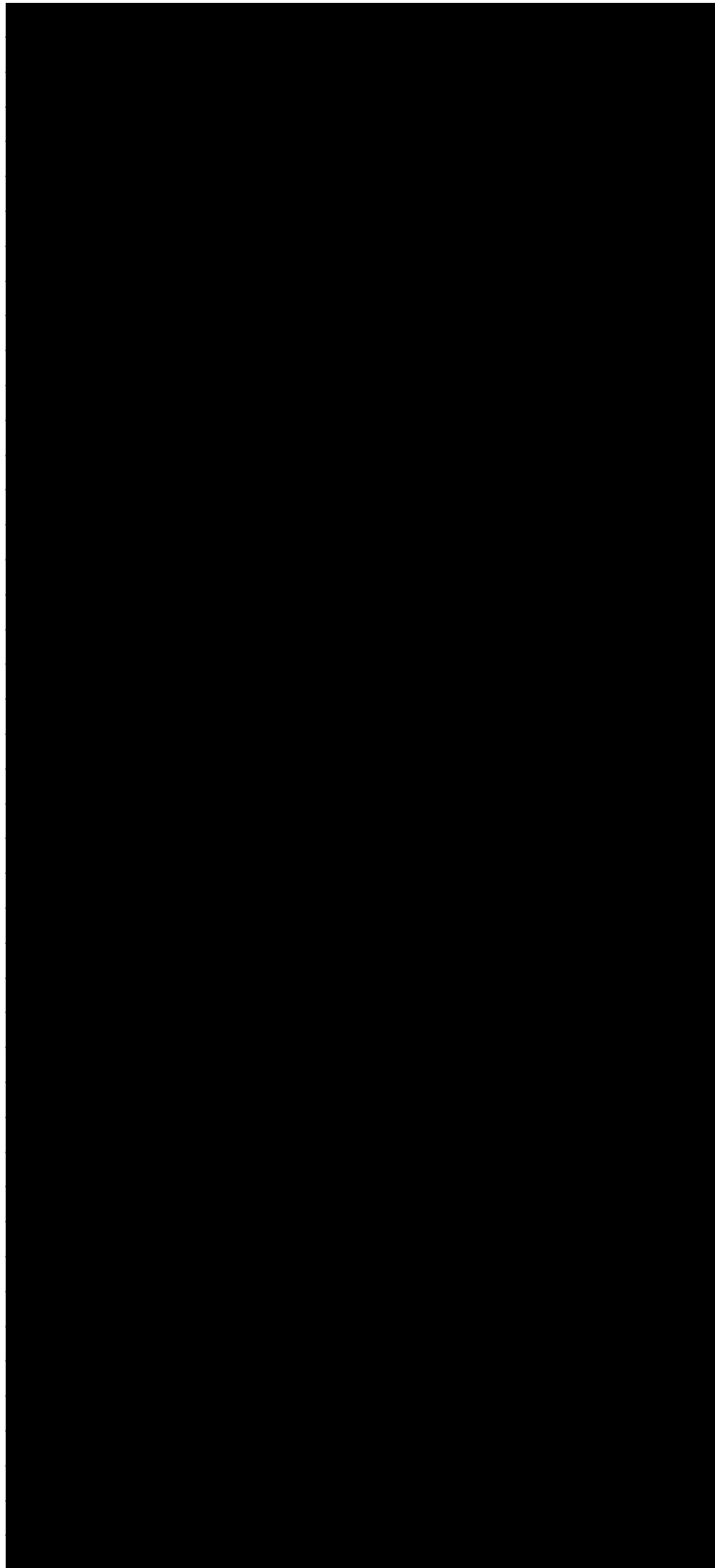


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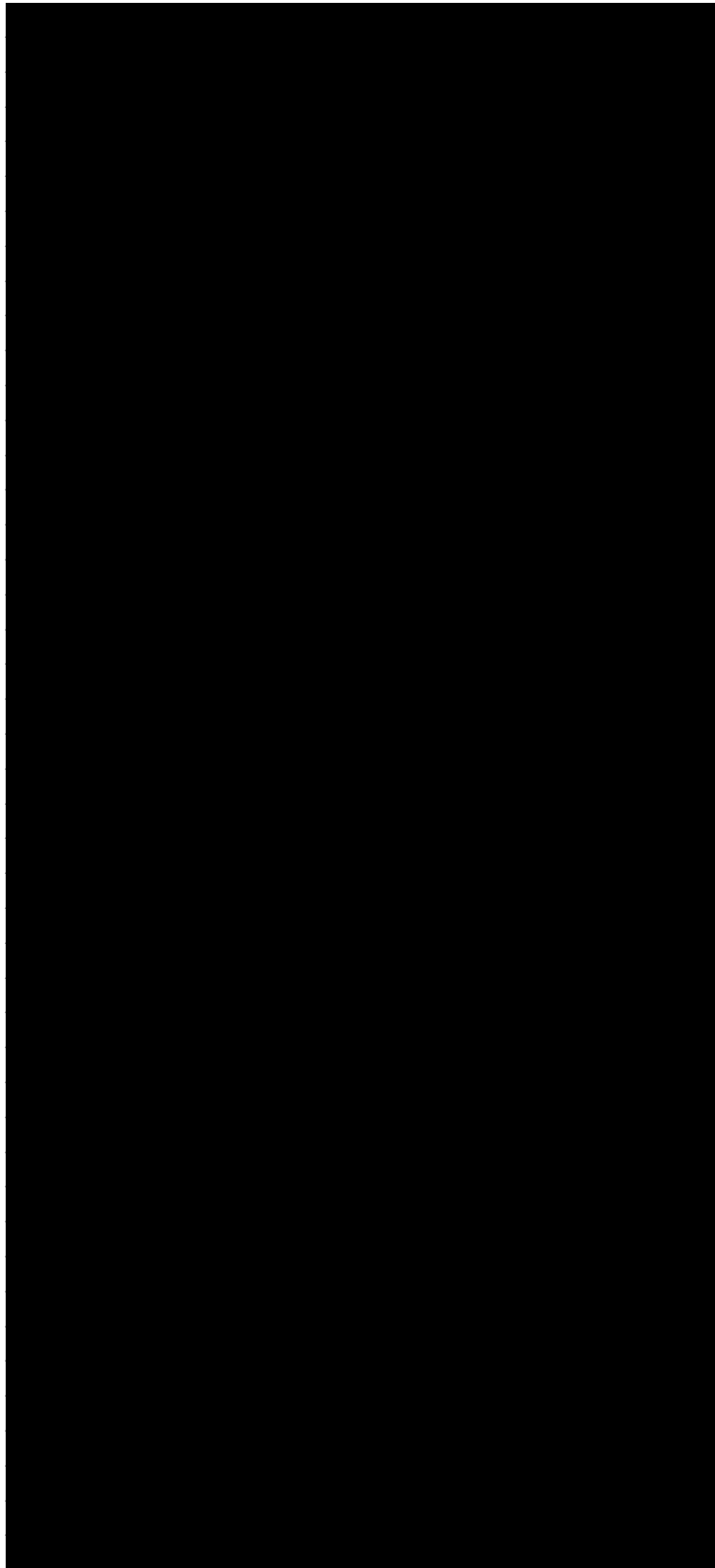


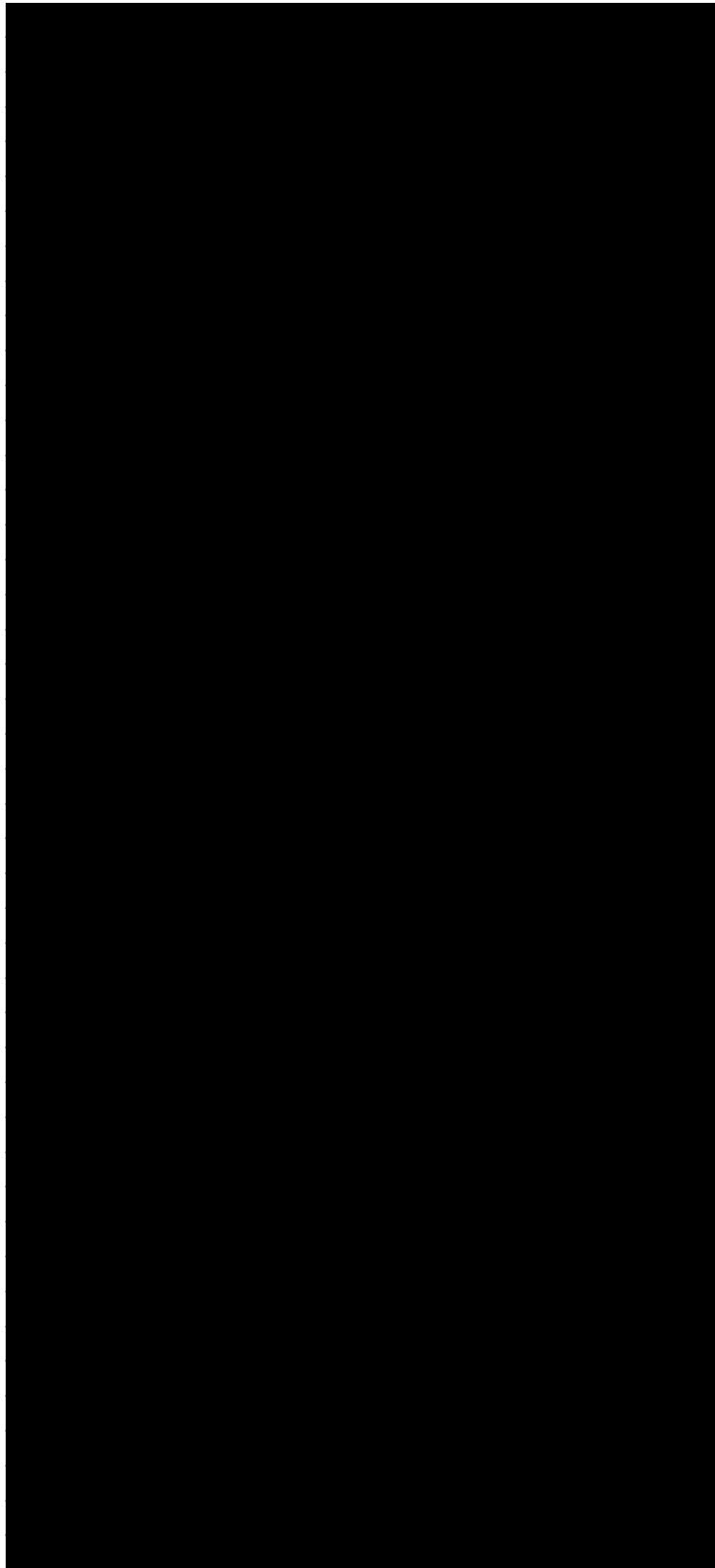
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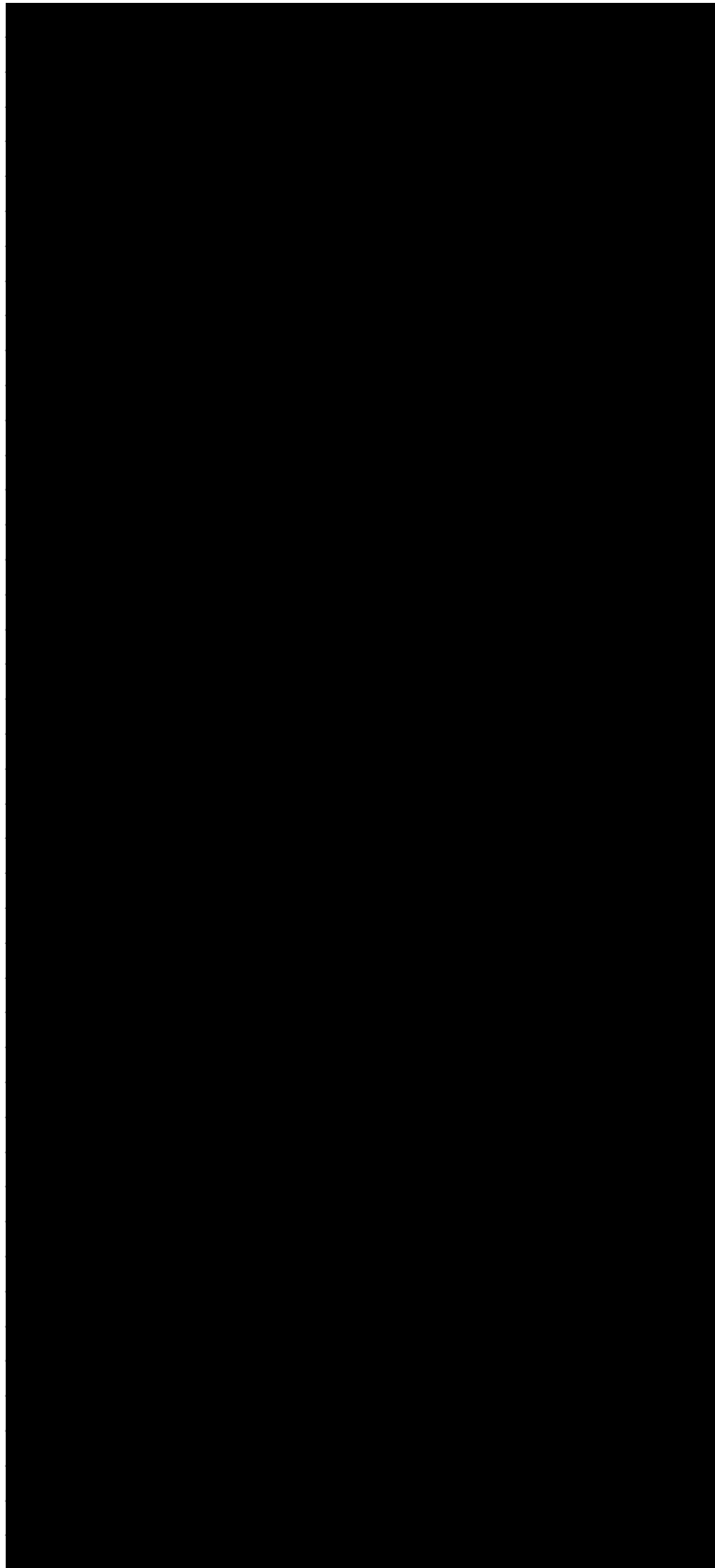




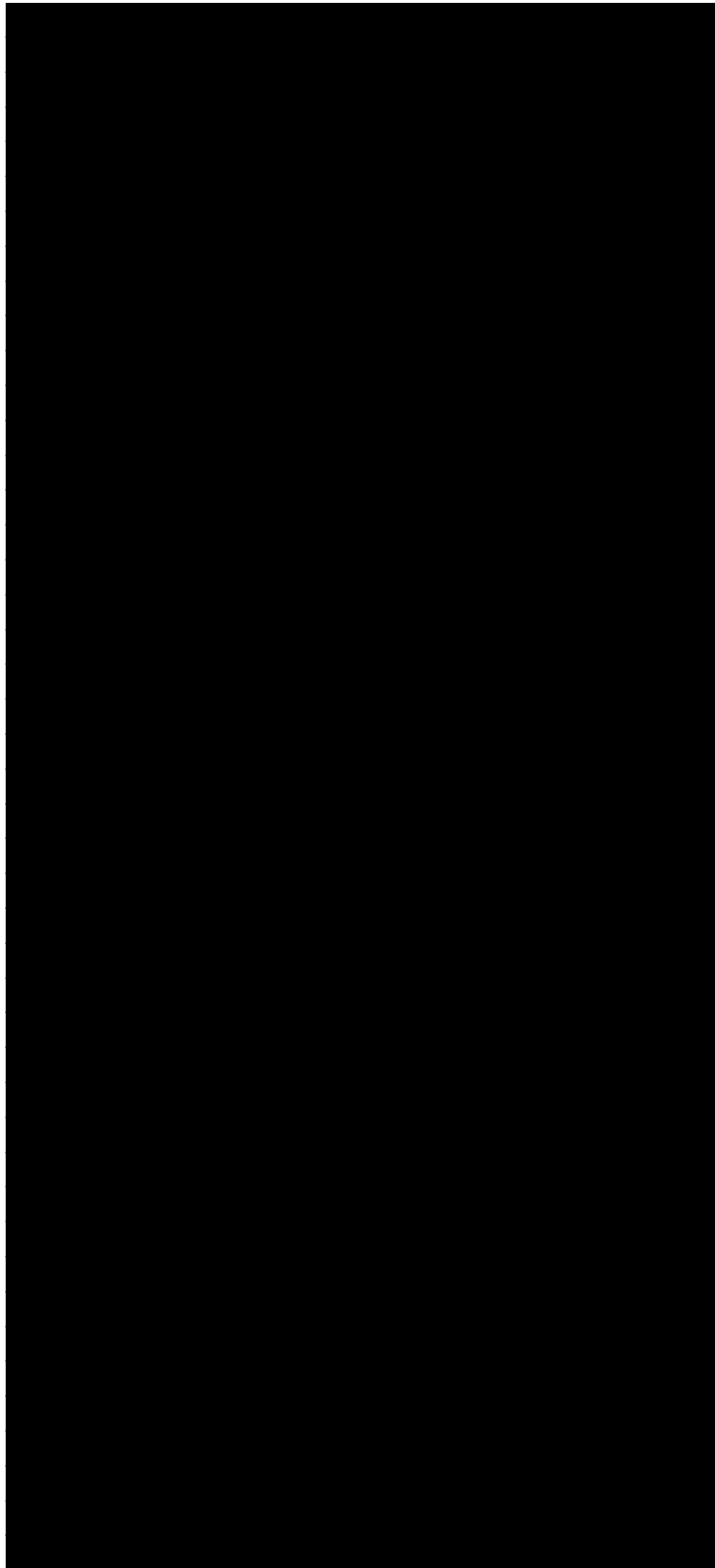
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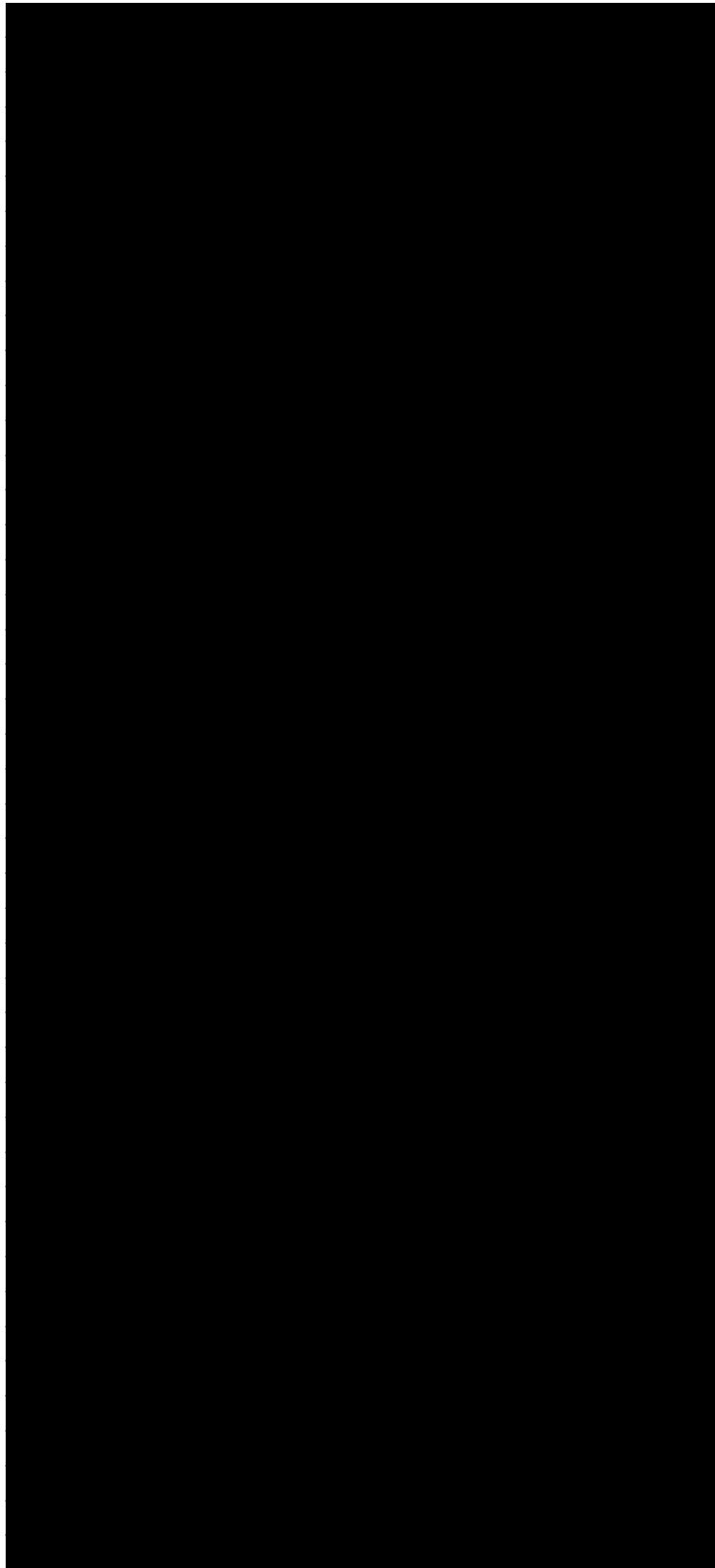




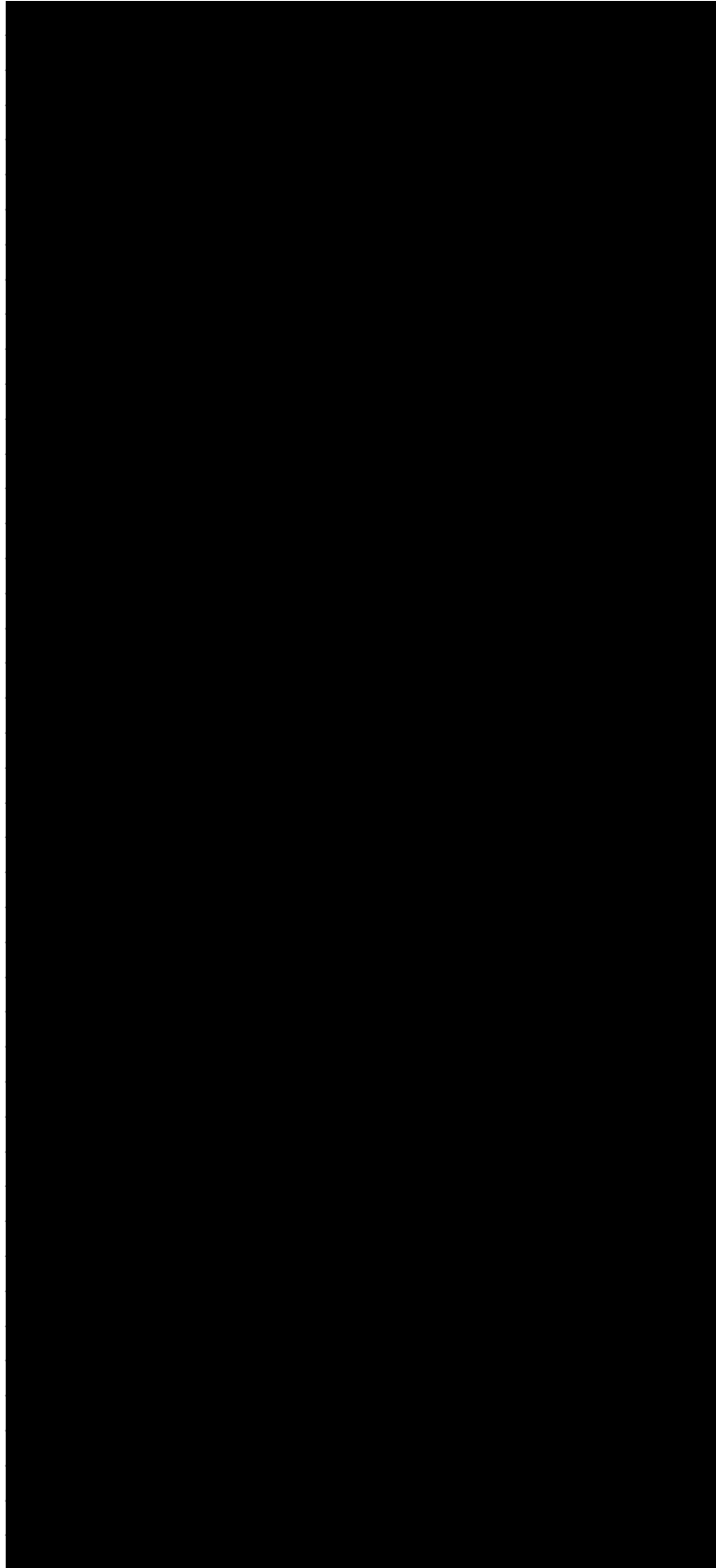
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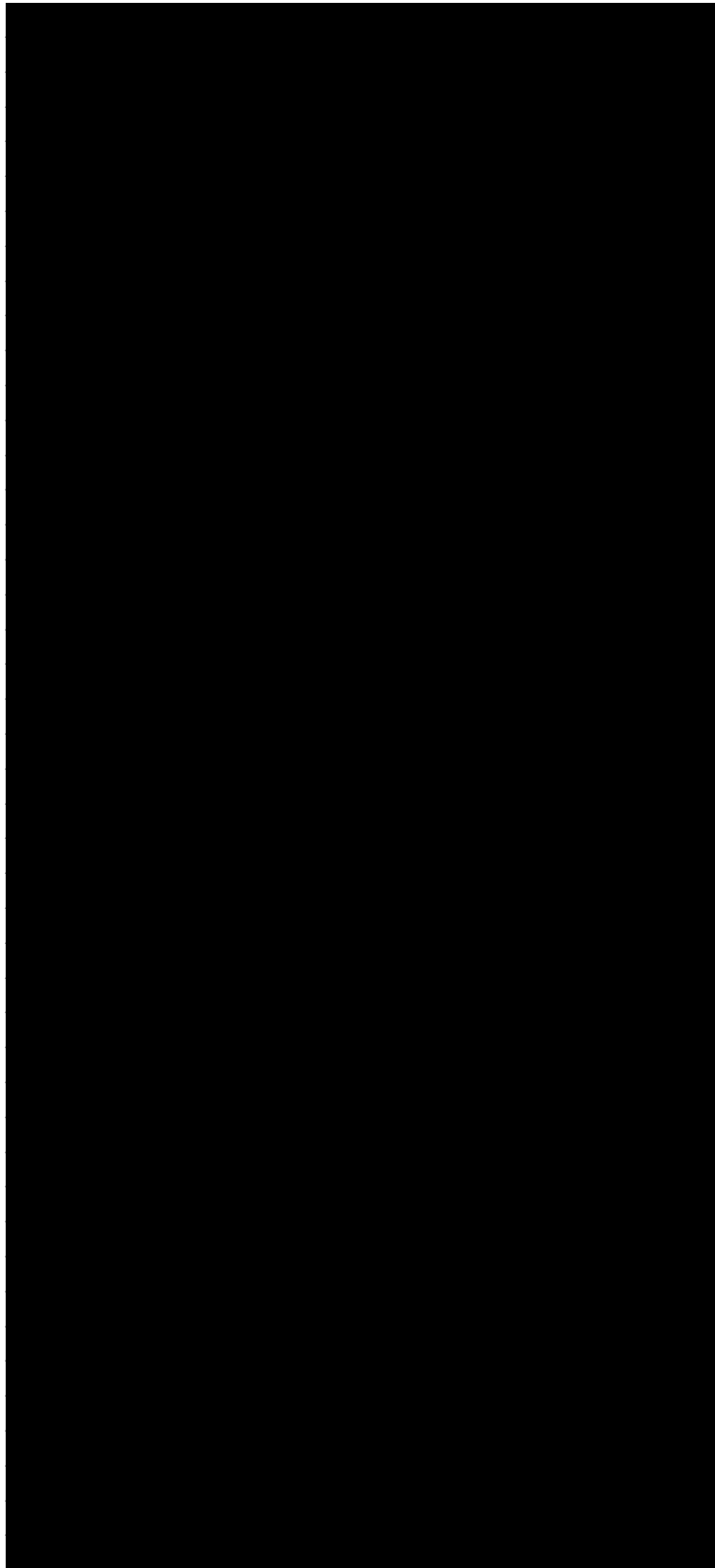
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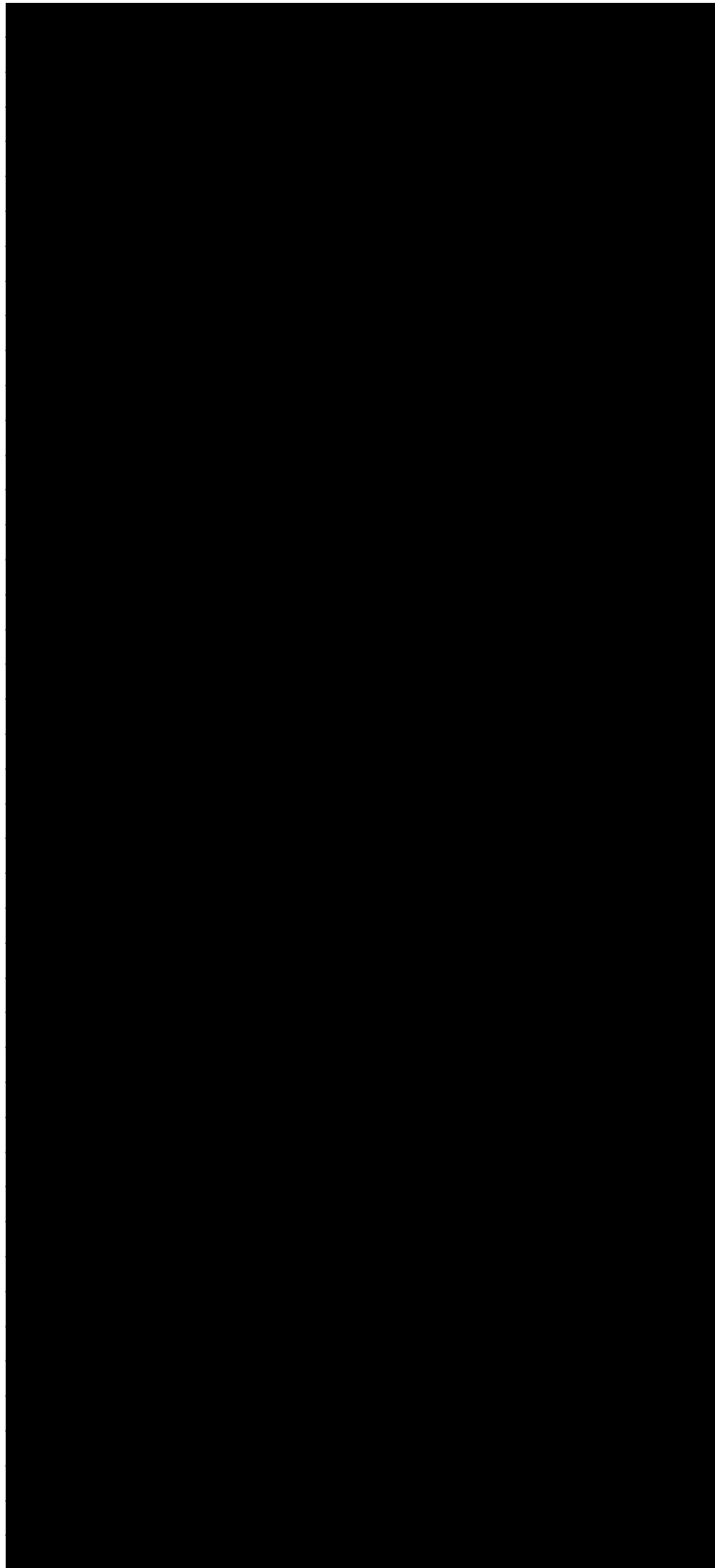
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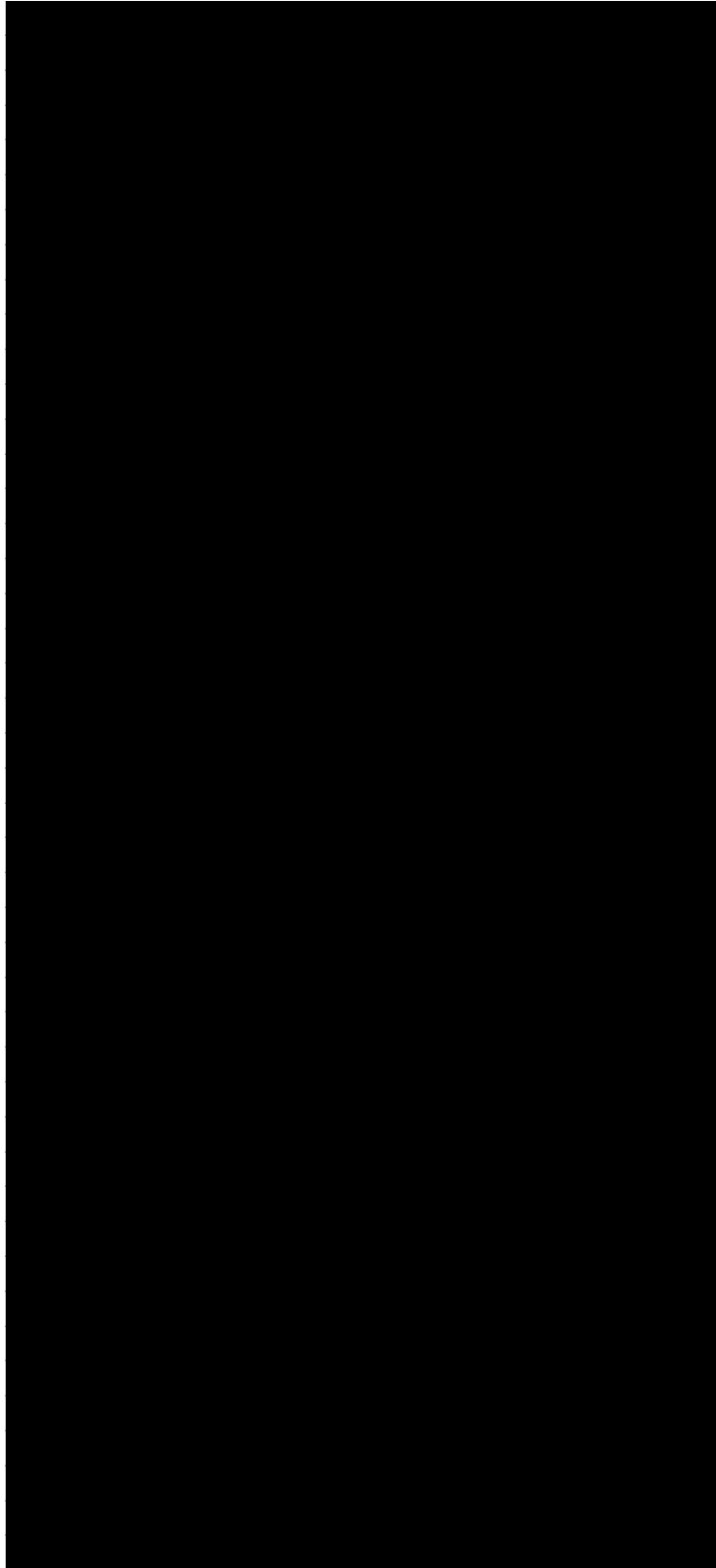
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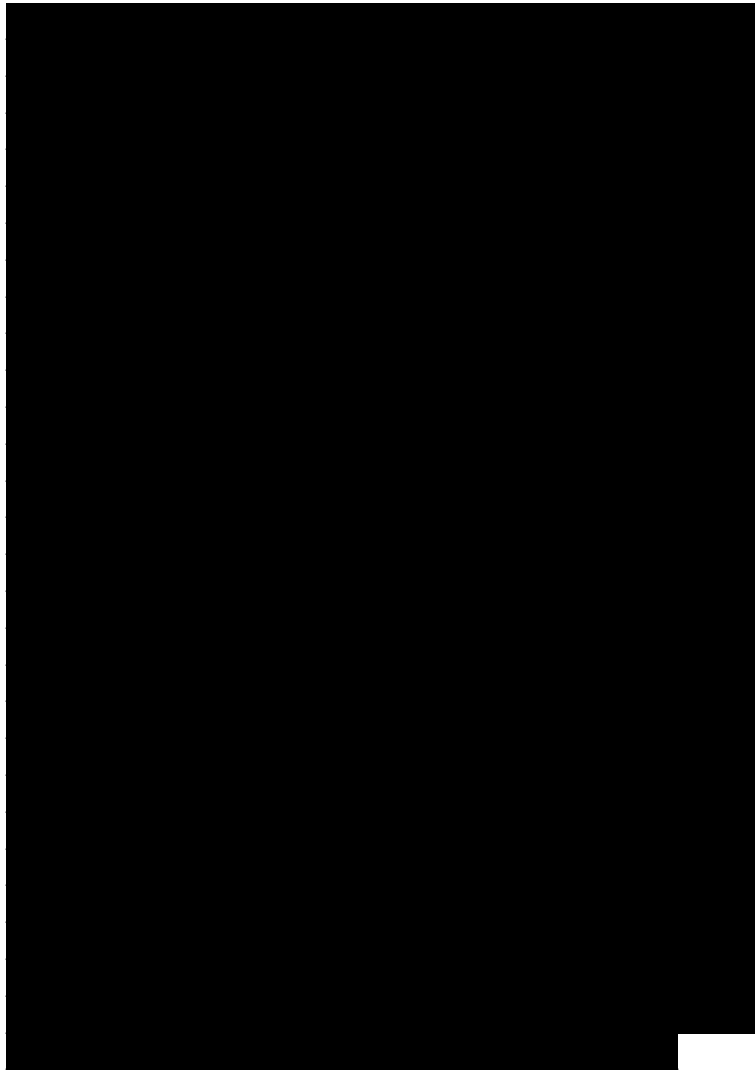


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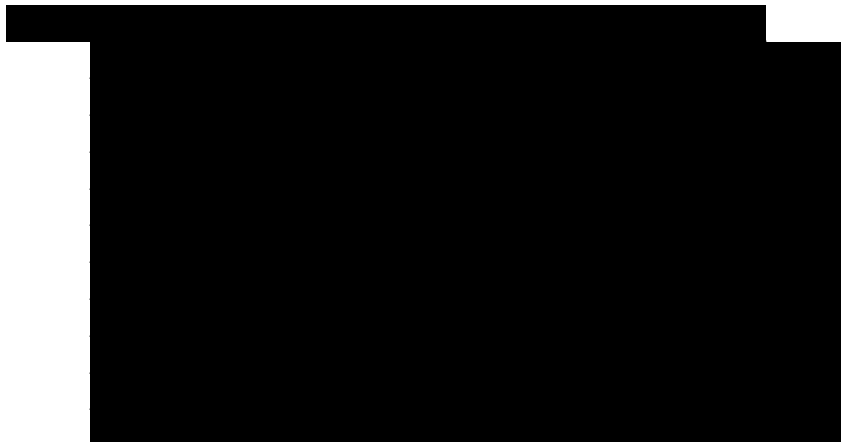


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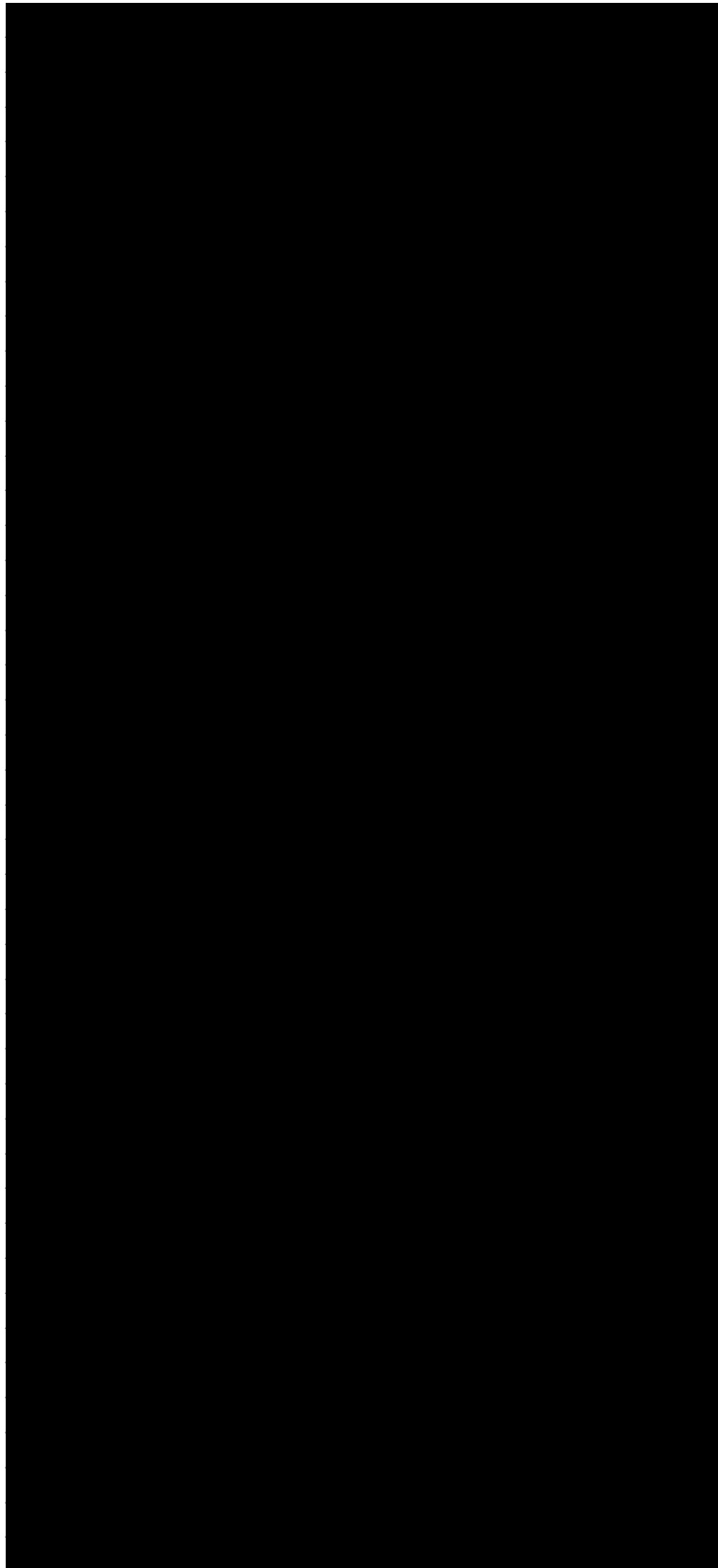




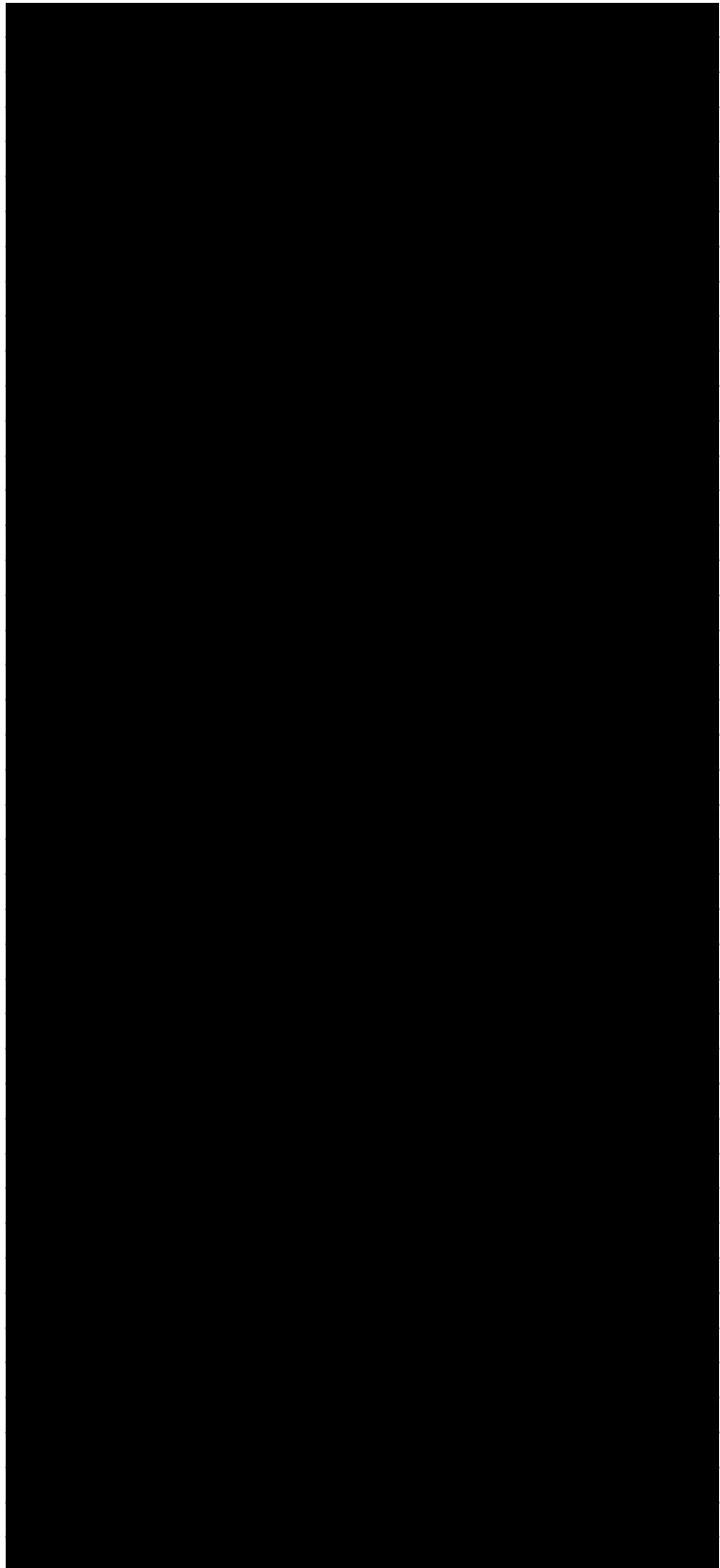
- (ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:



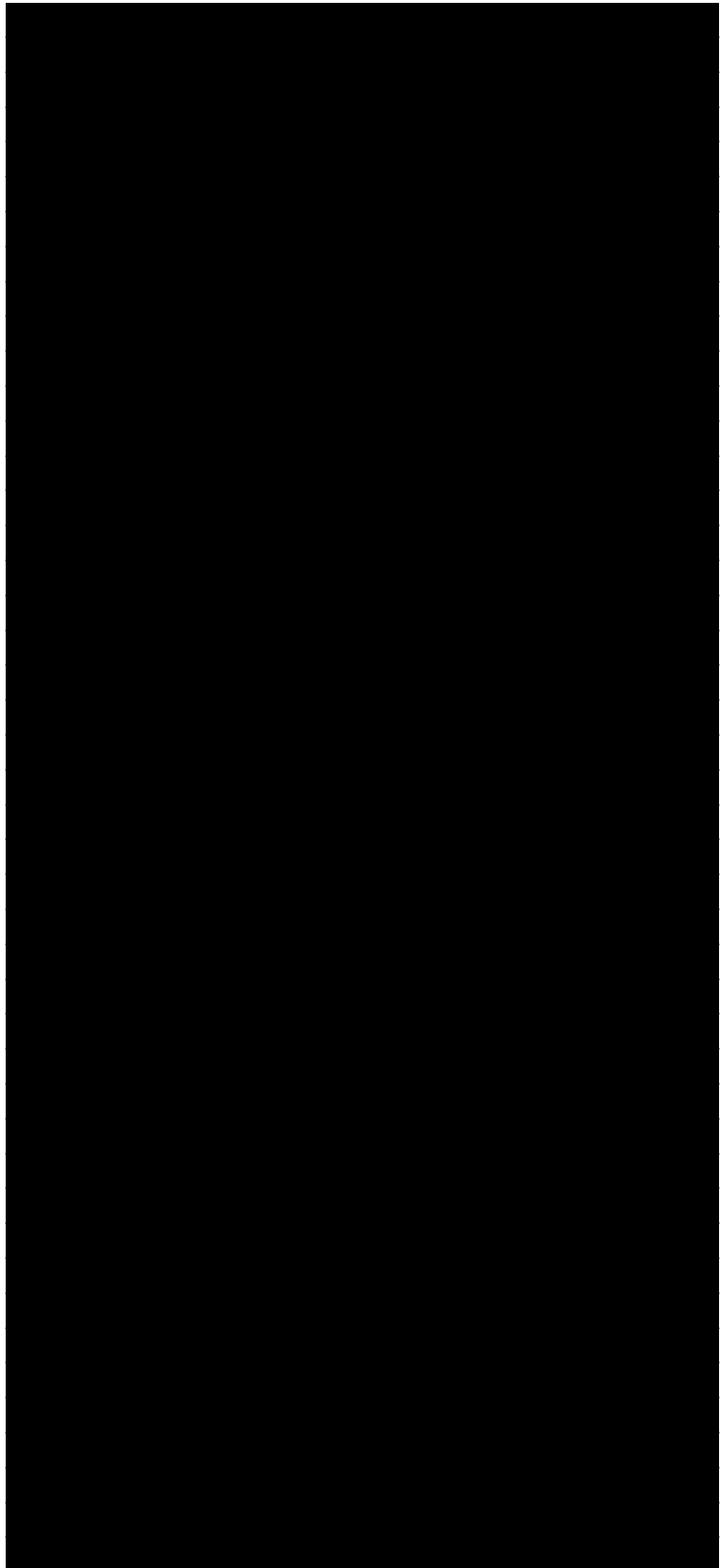
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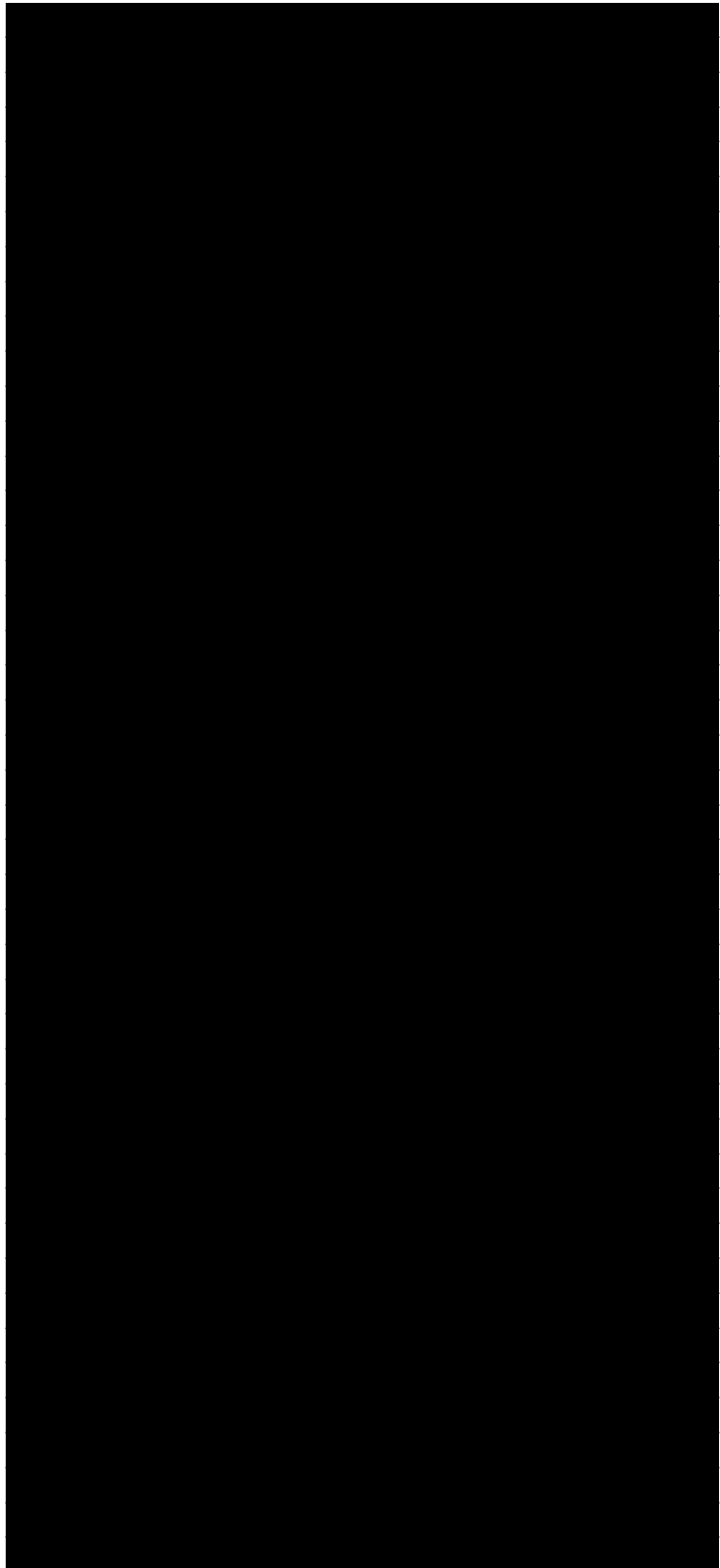
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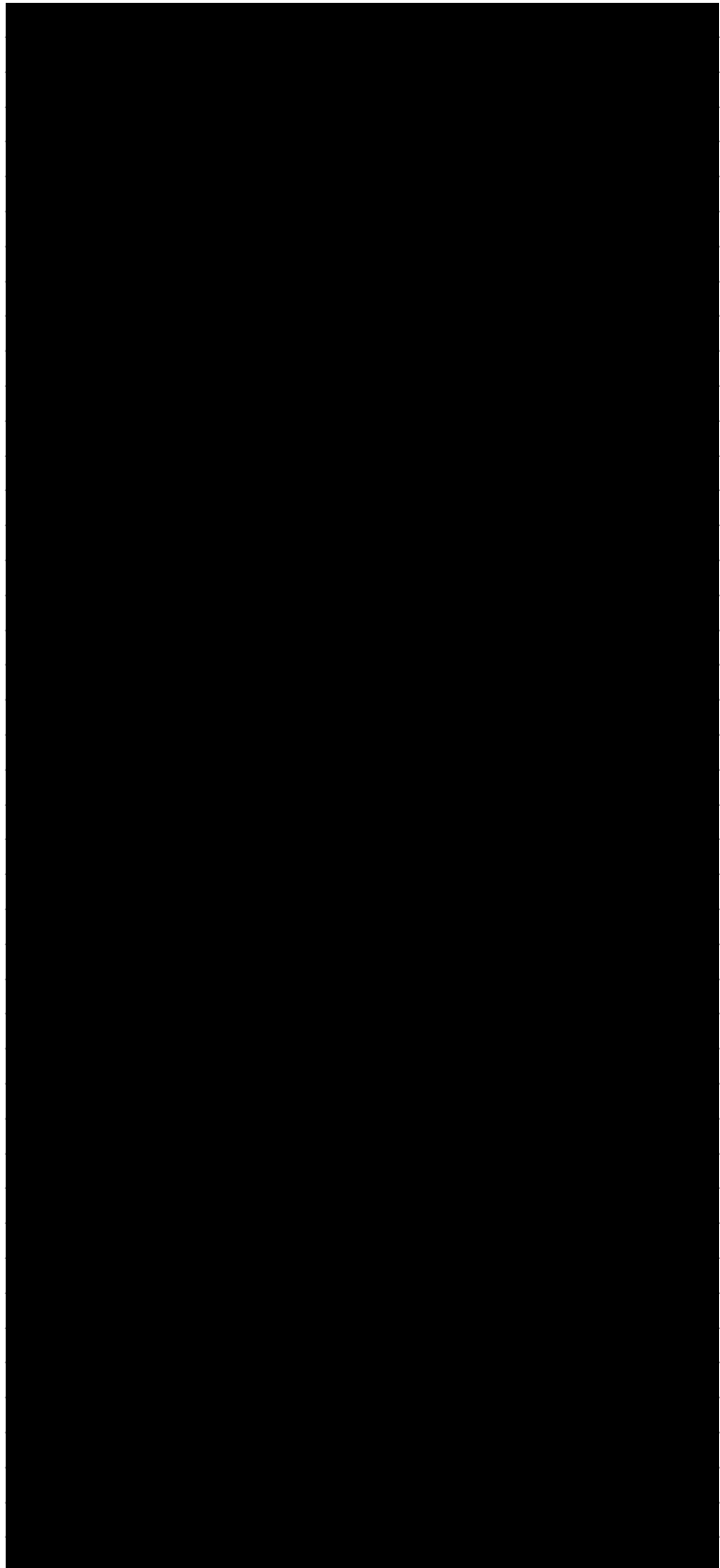
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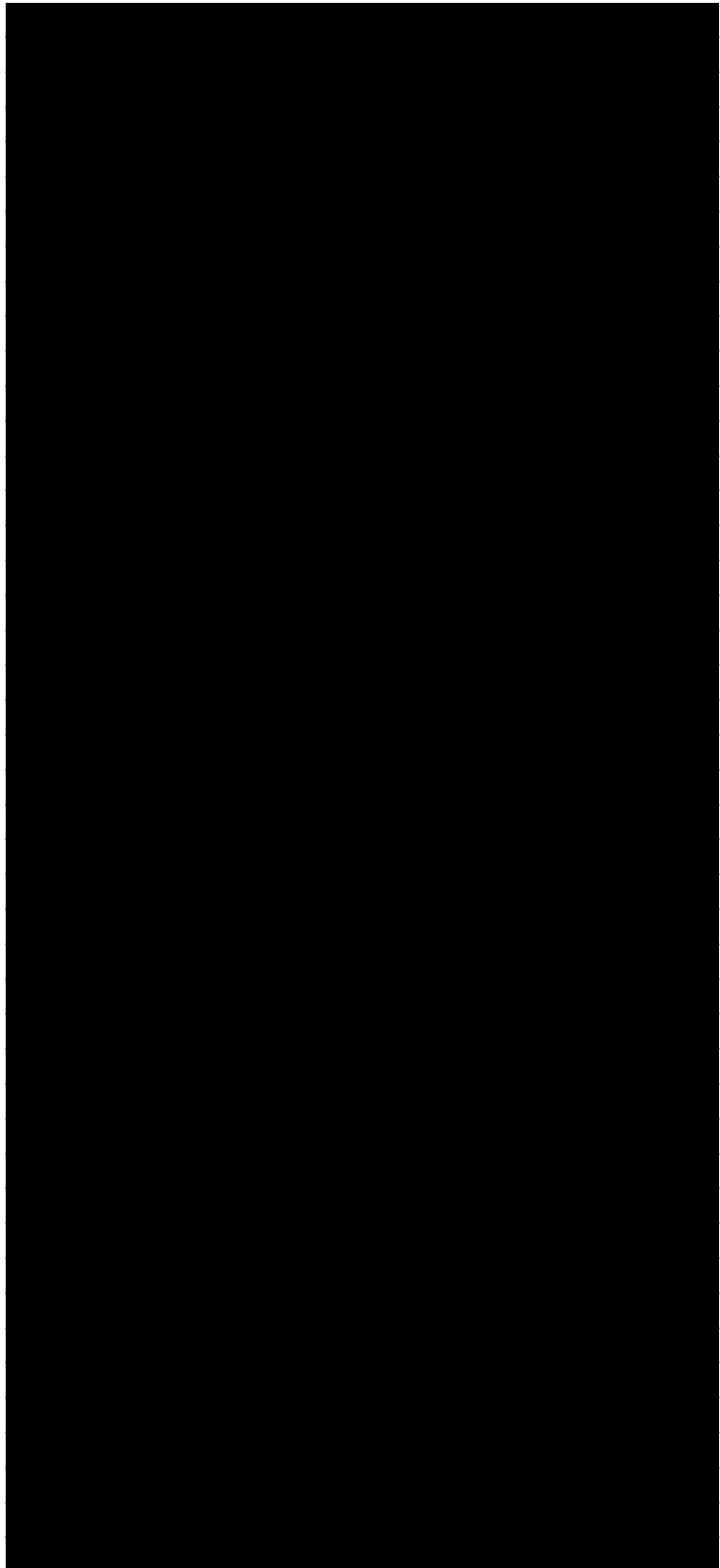


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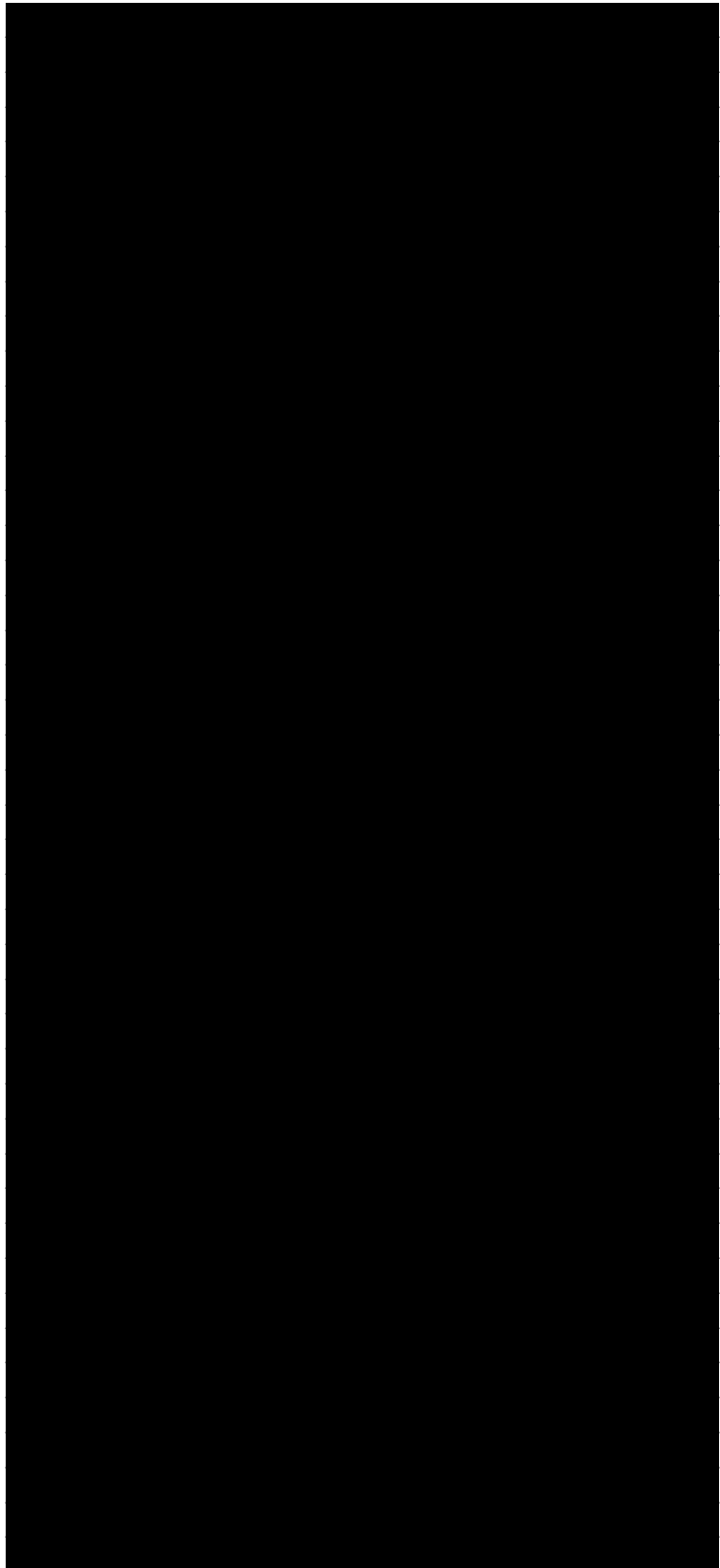




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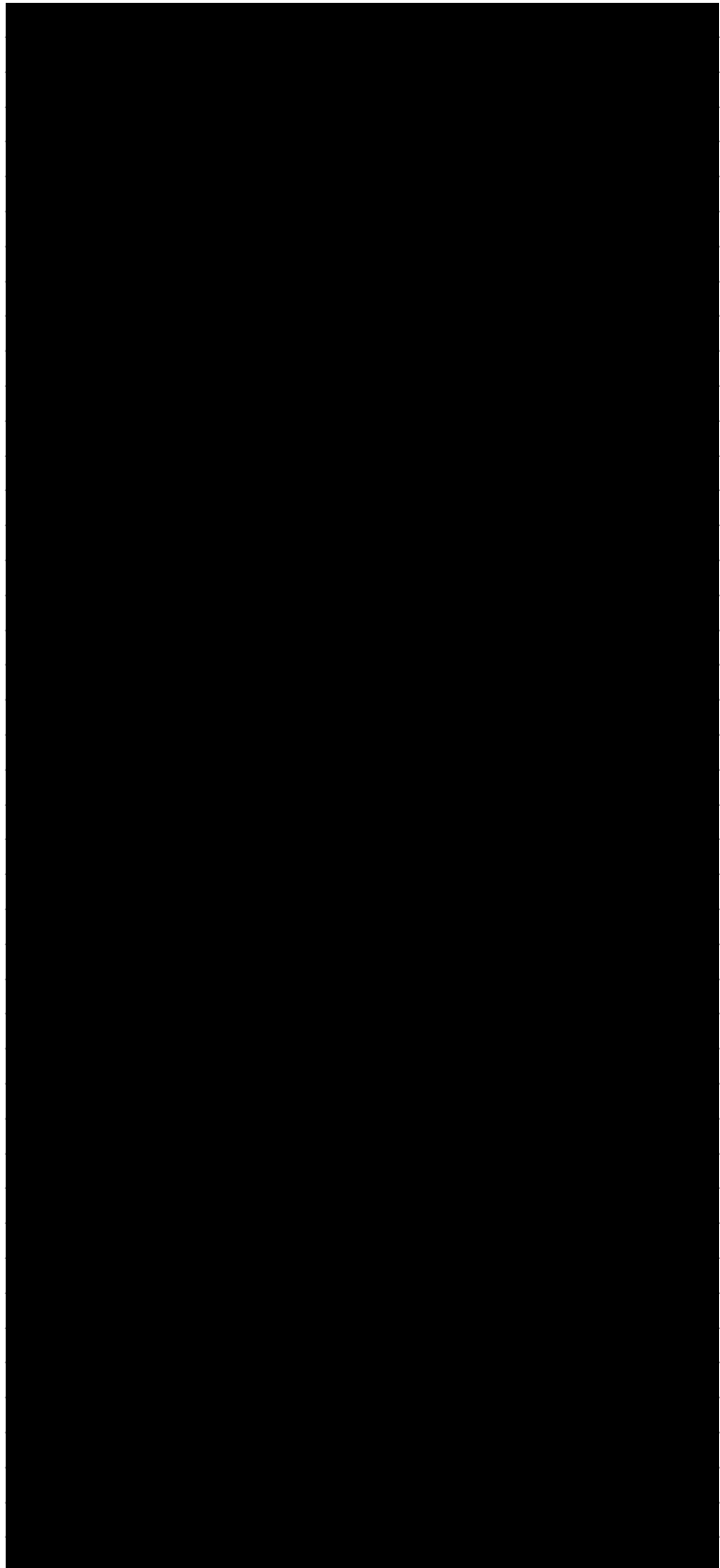




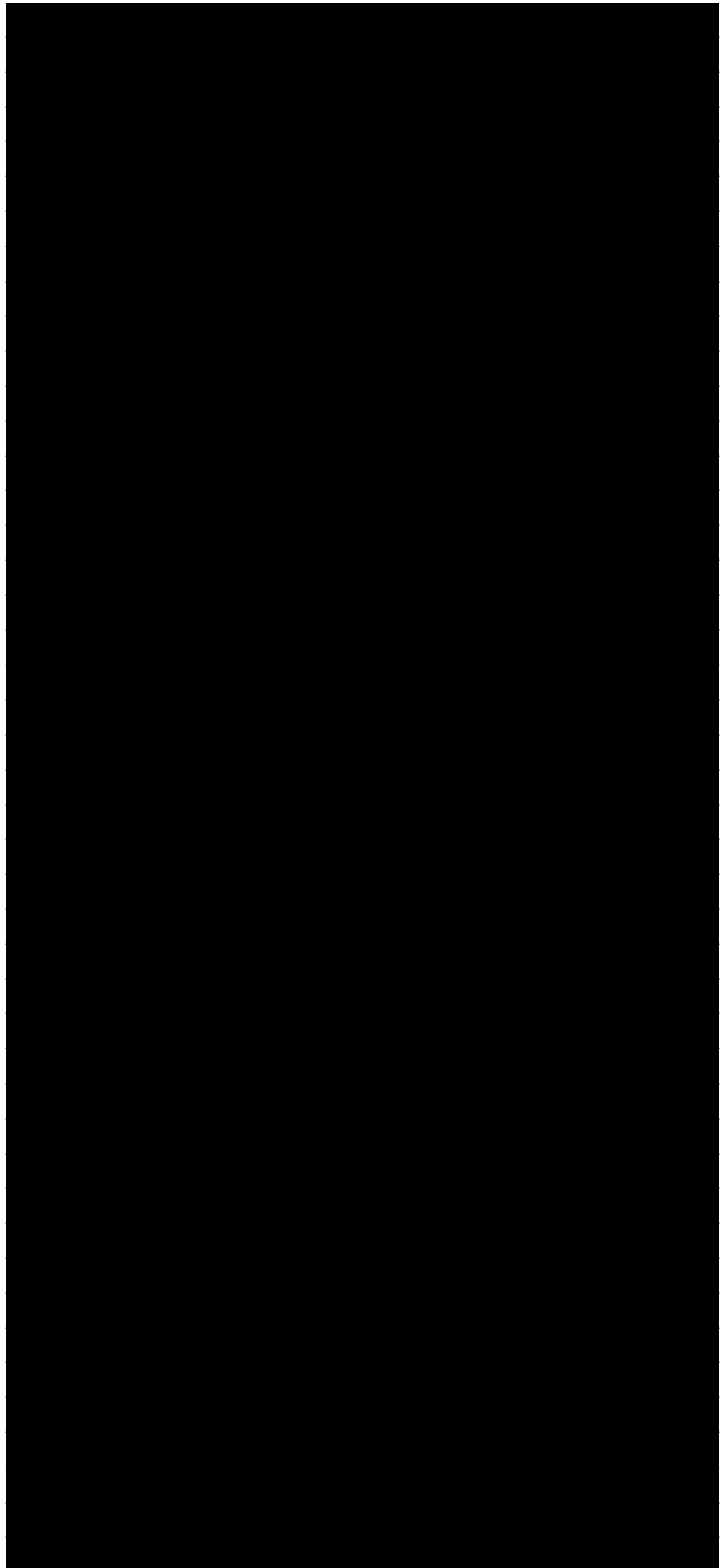
- (B) The ability to achieve age-appropriate growth and development.



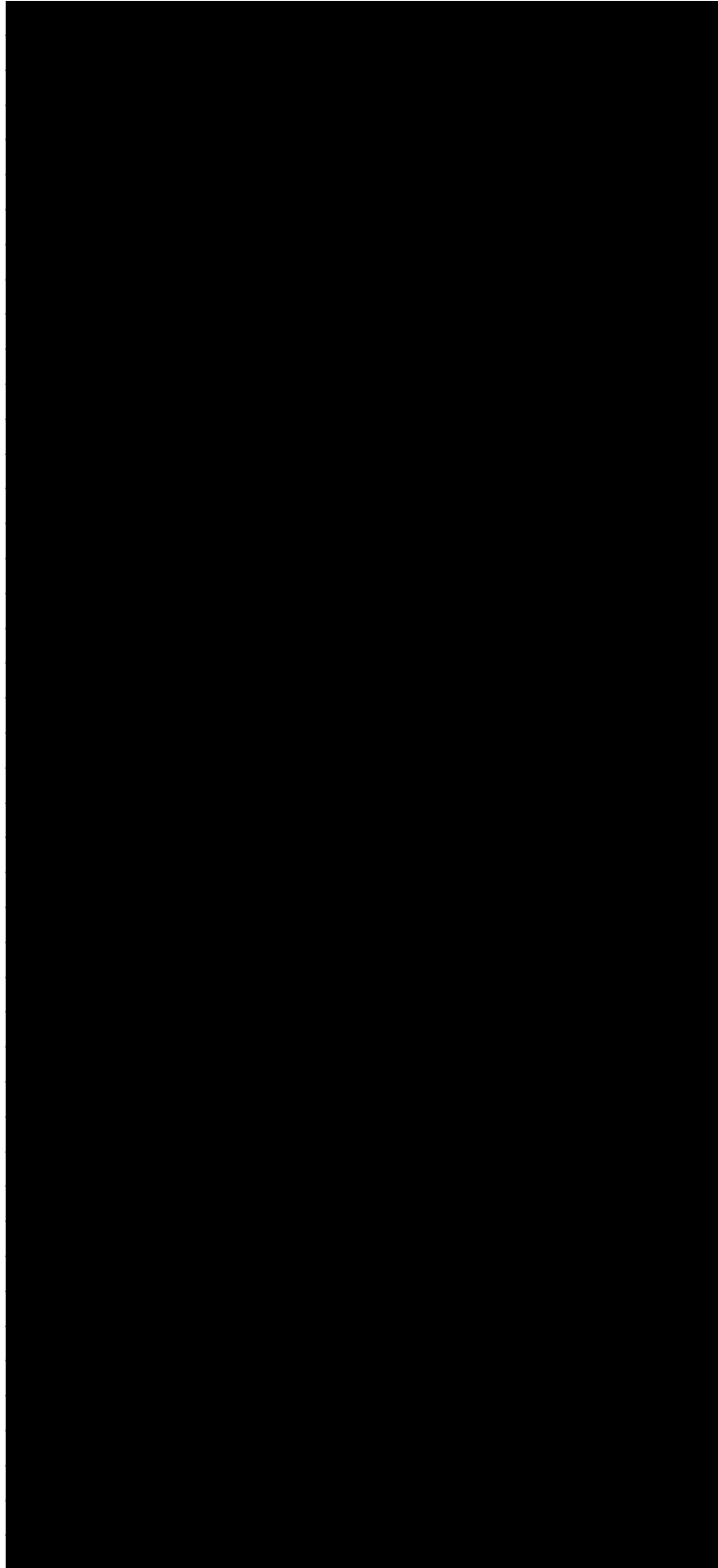
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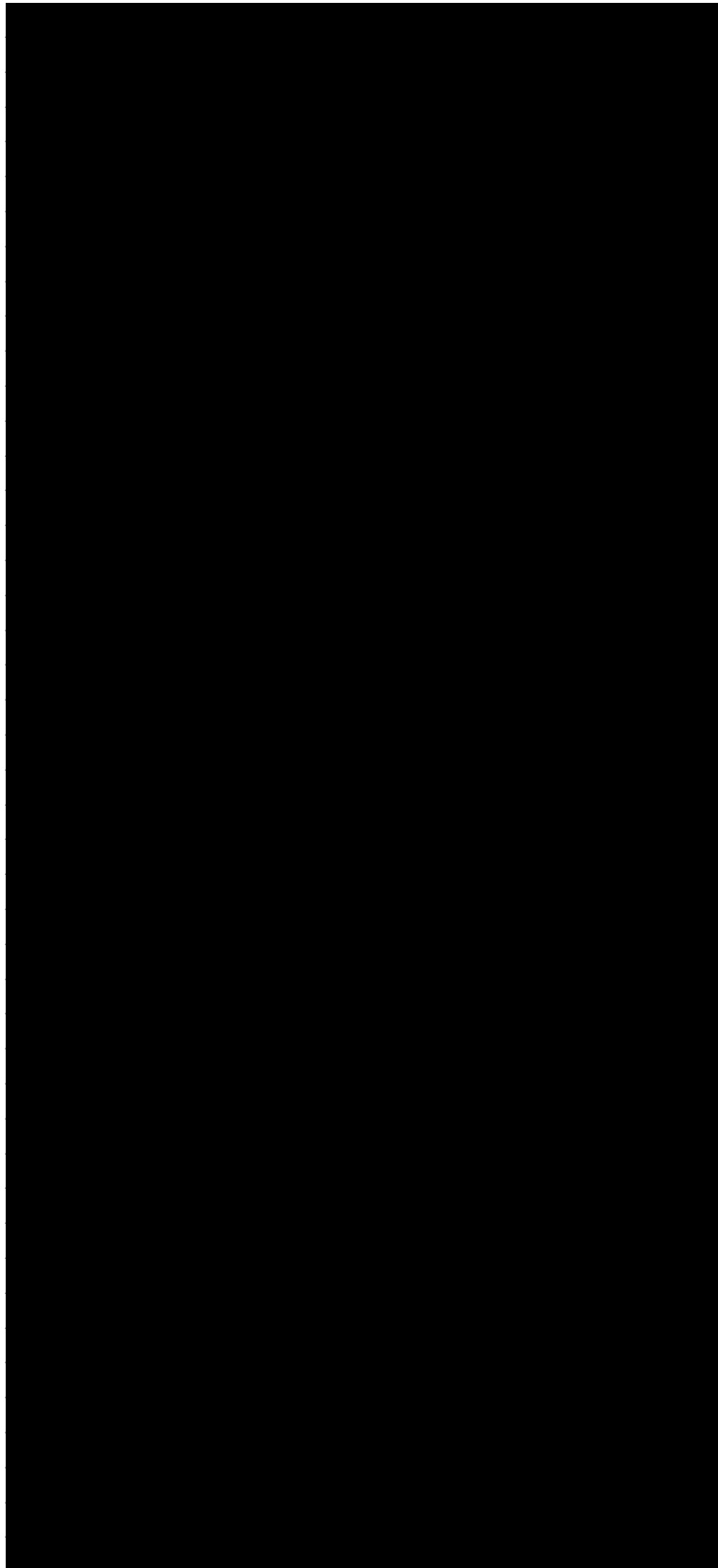


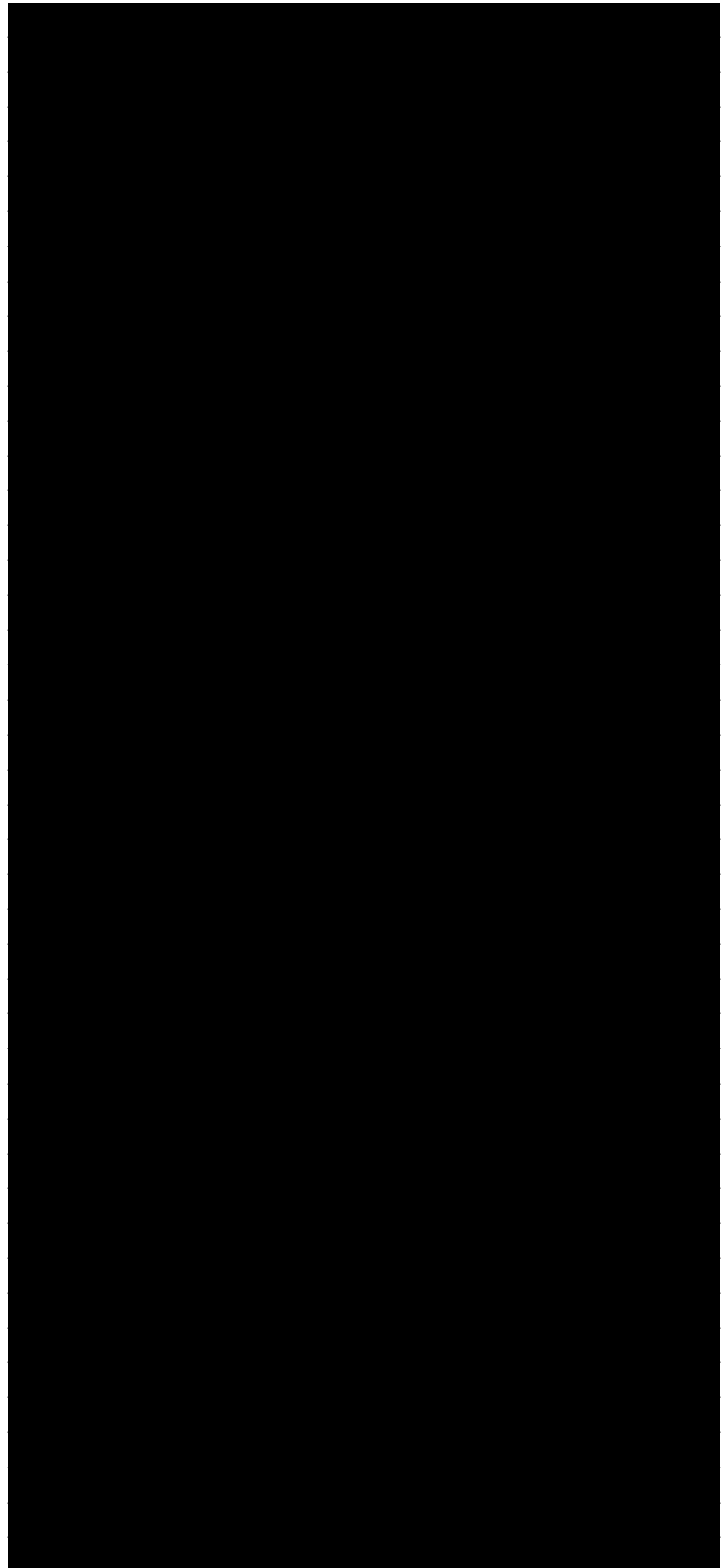
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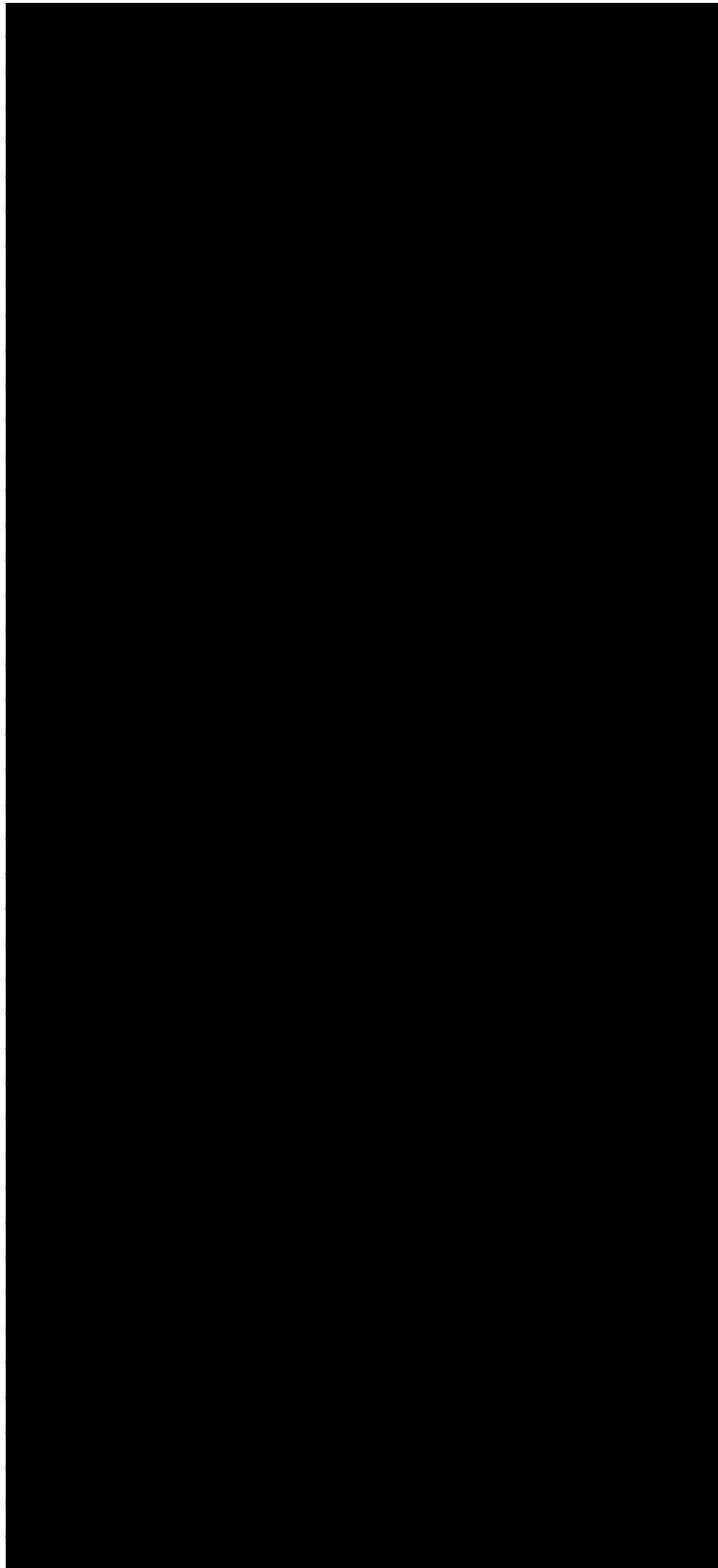


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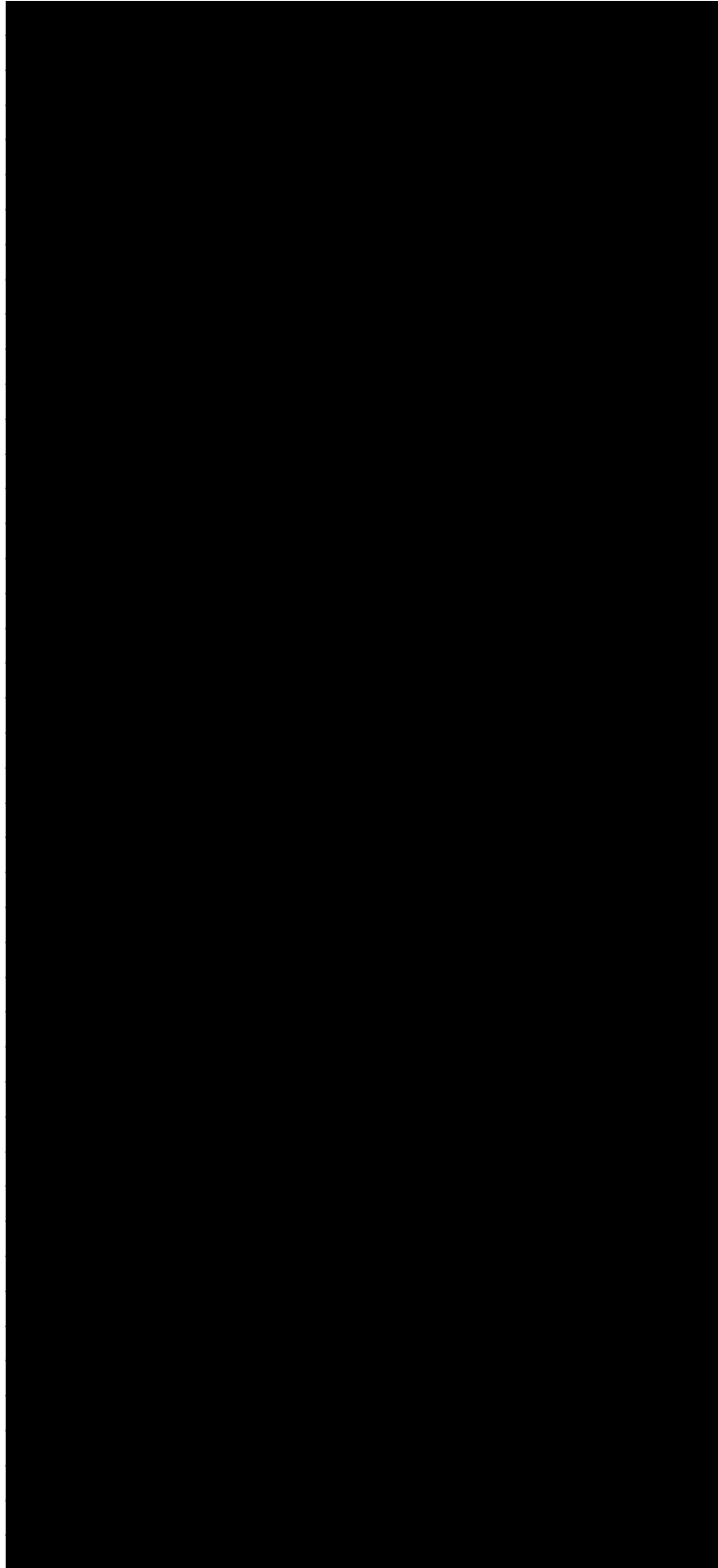




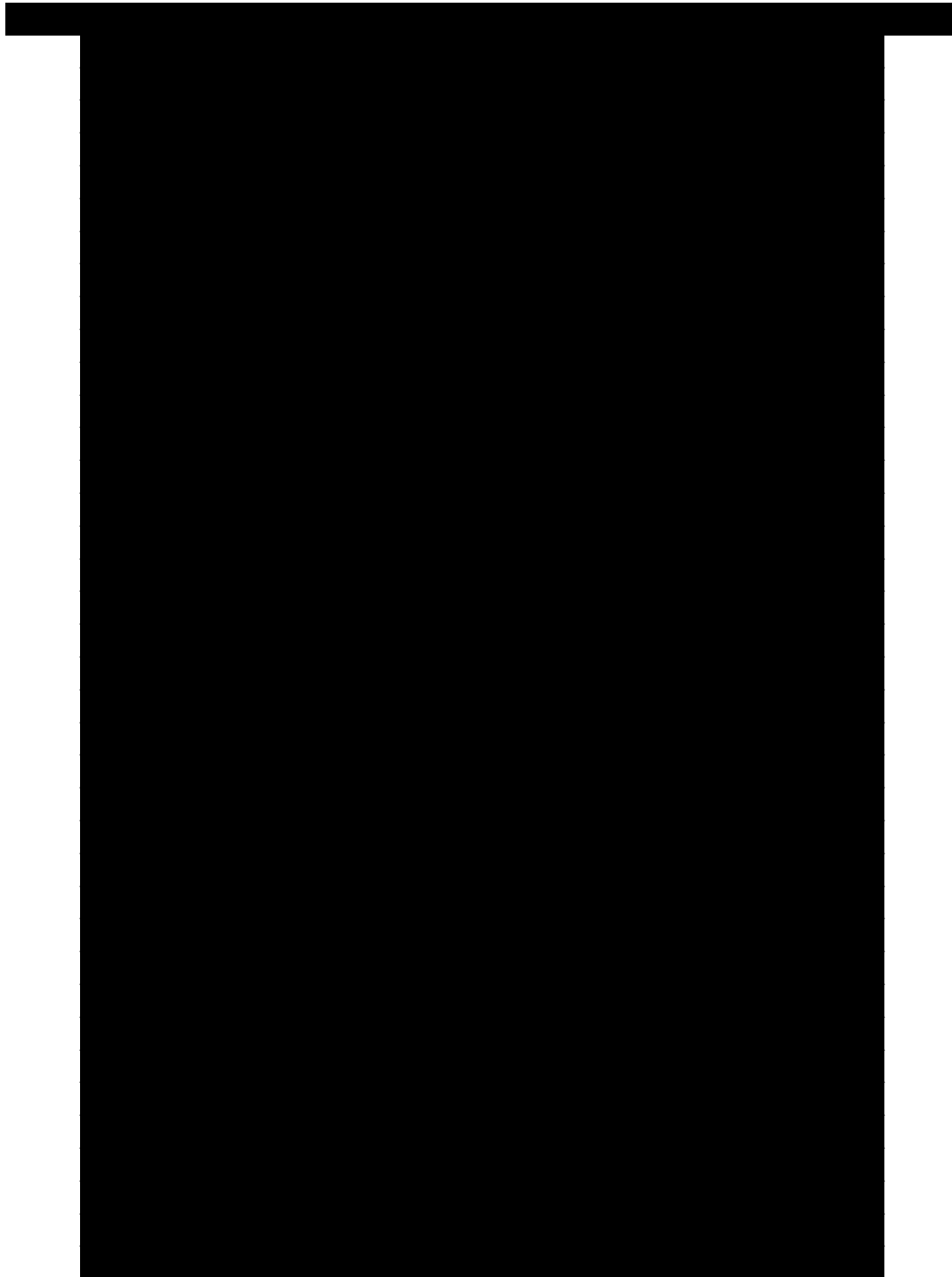




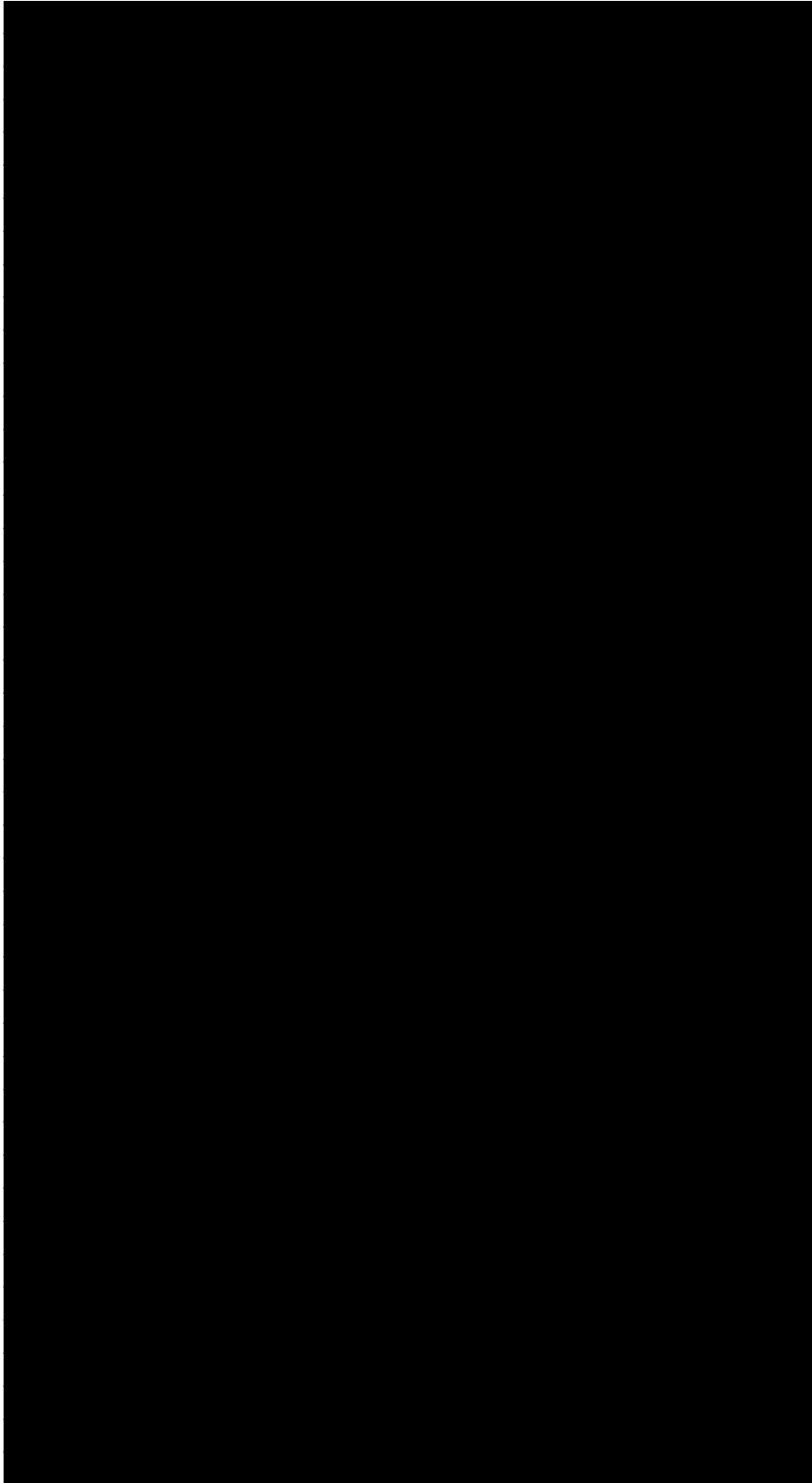
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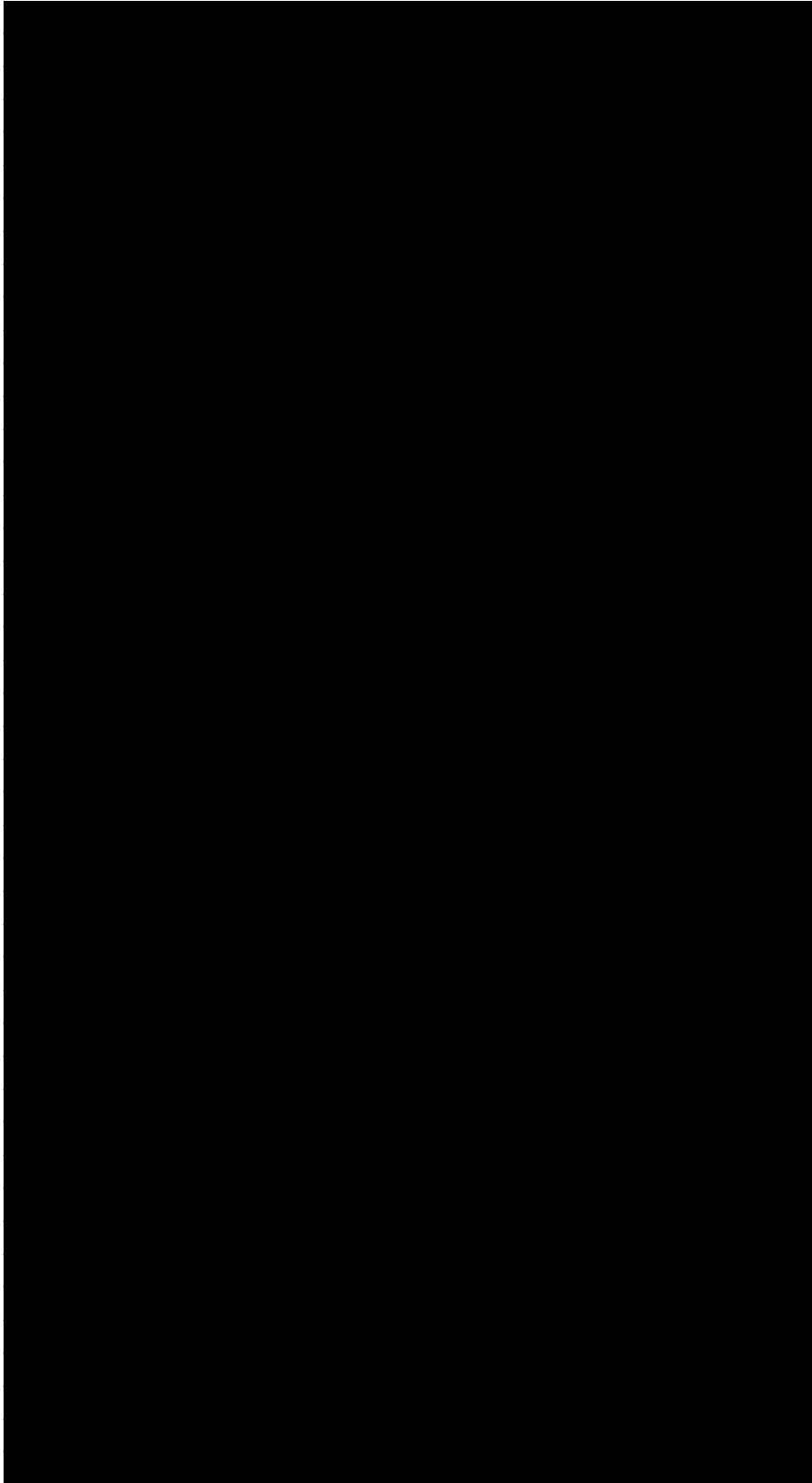
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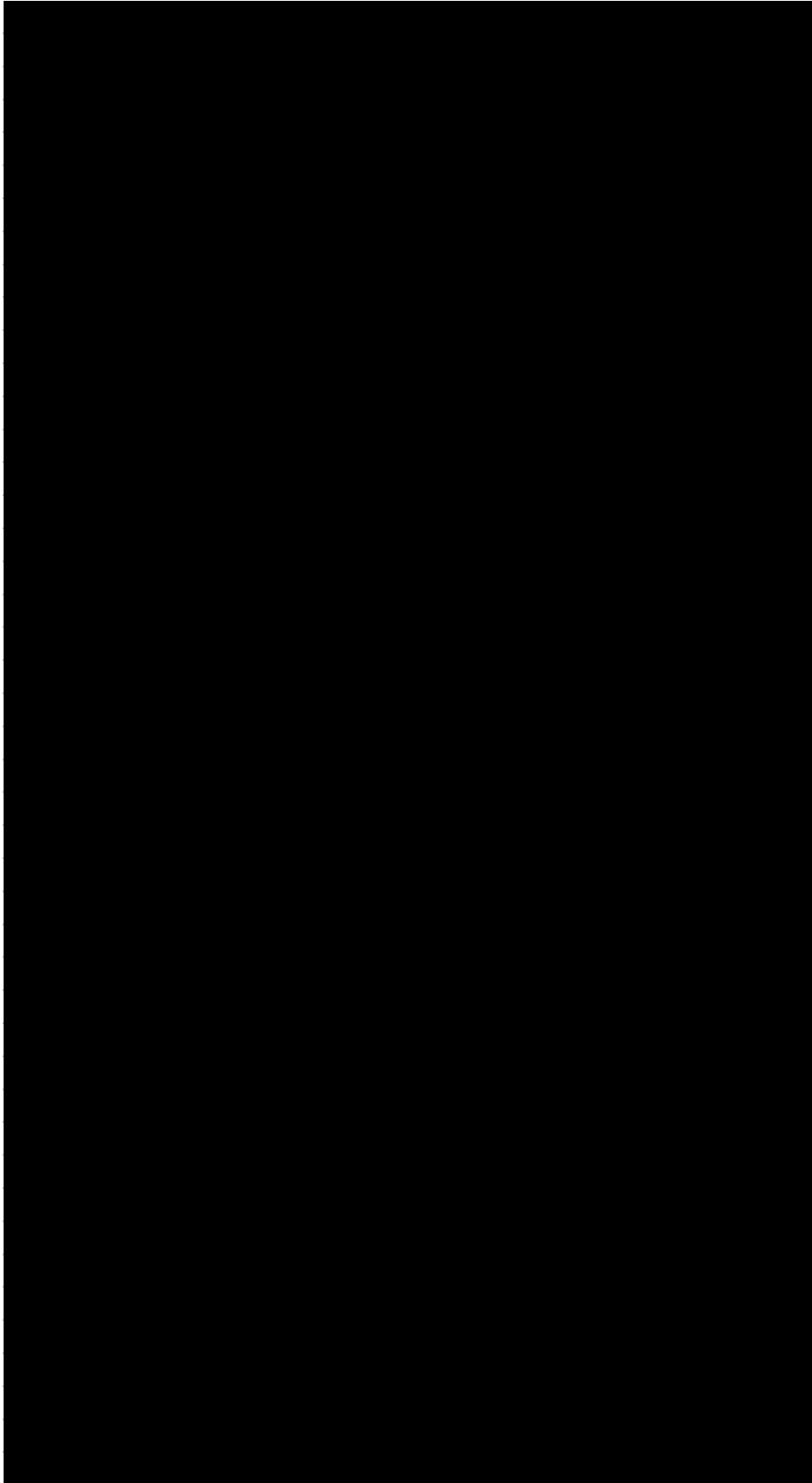
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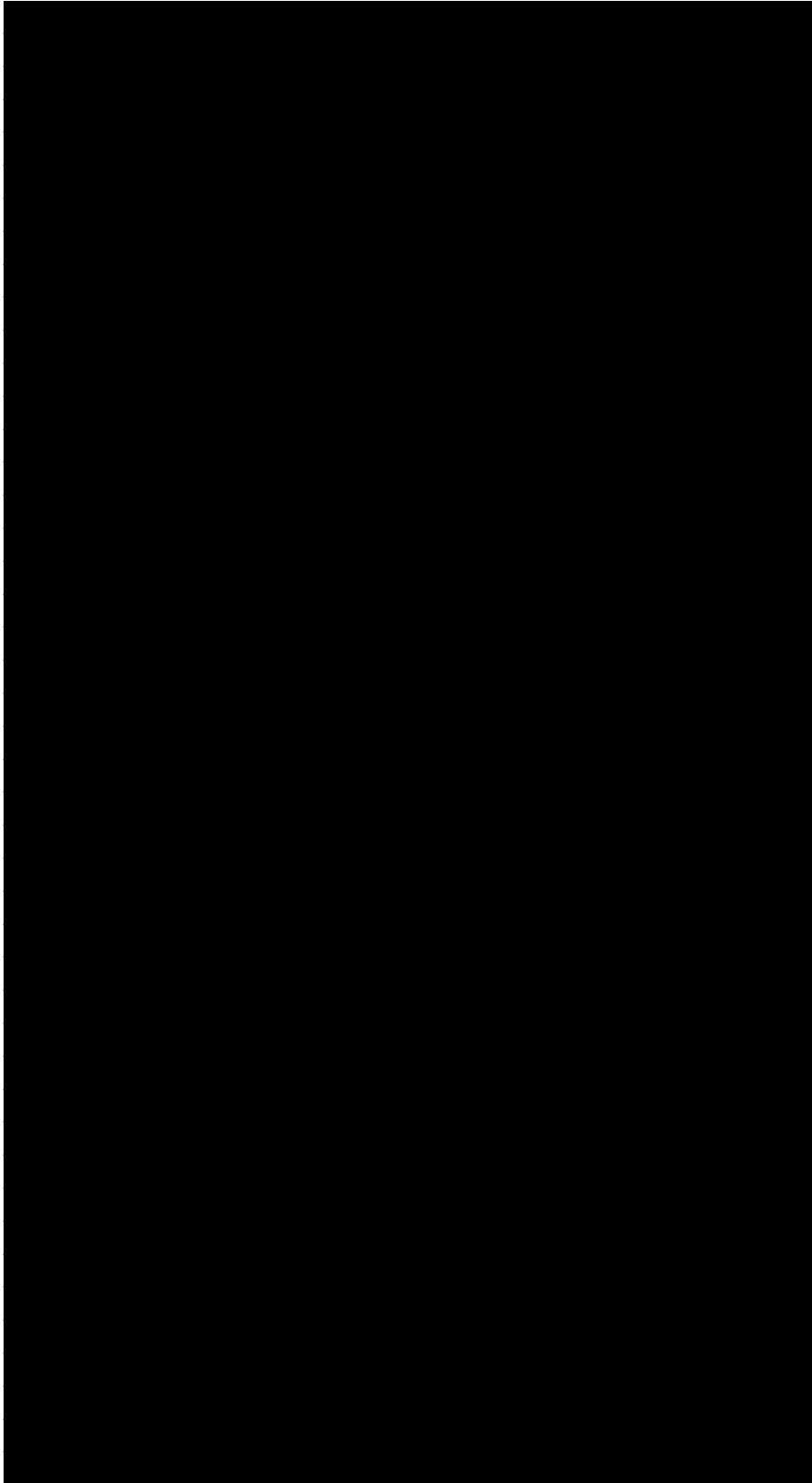
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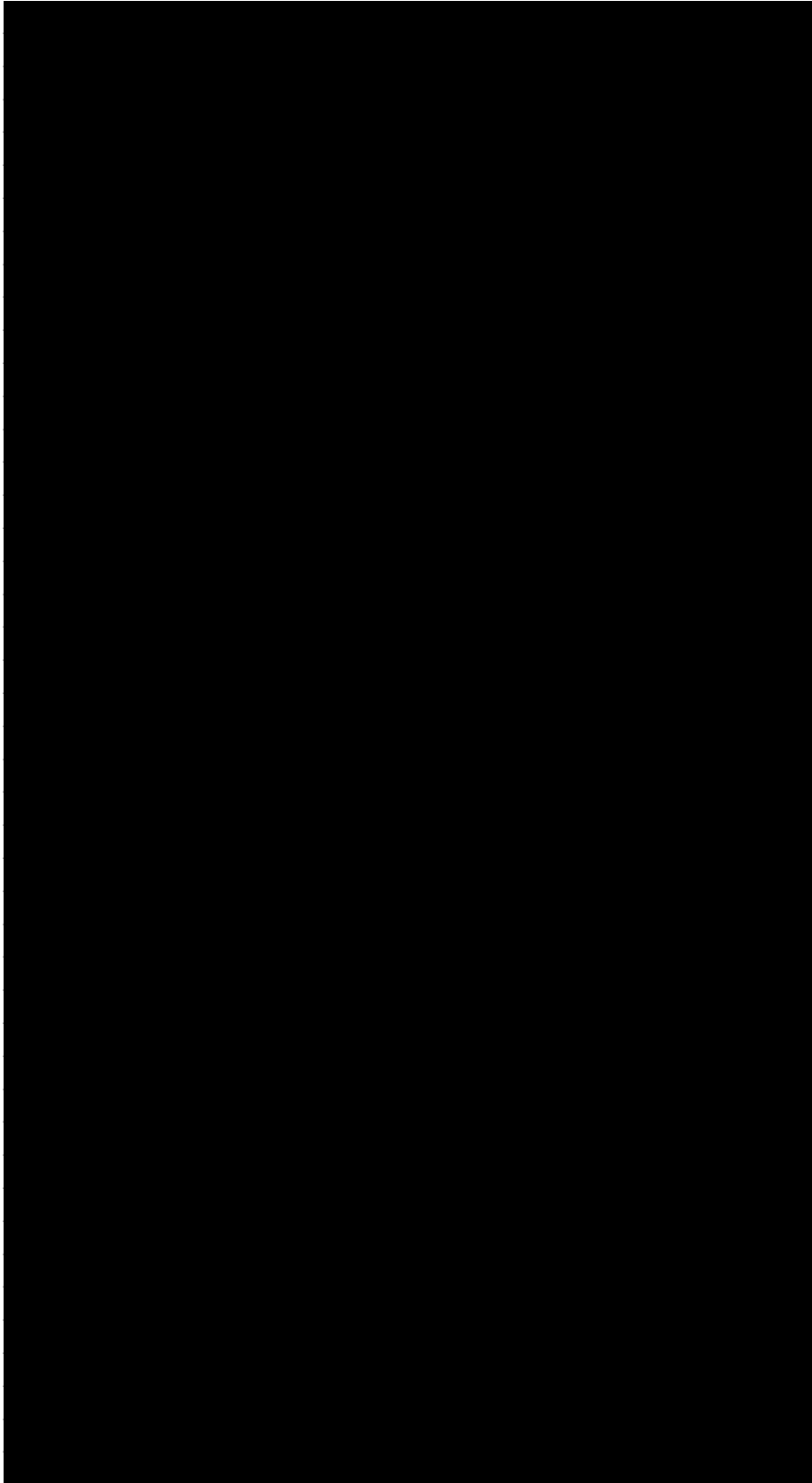


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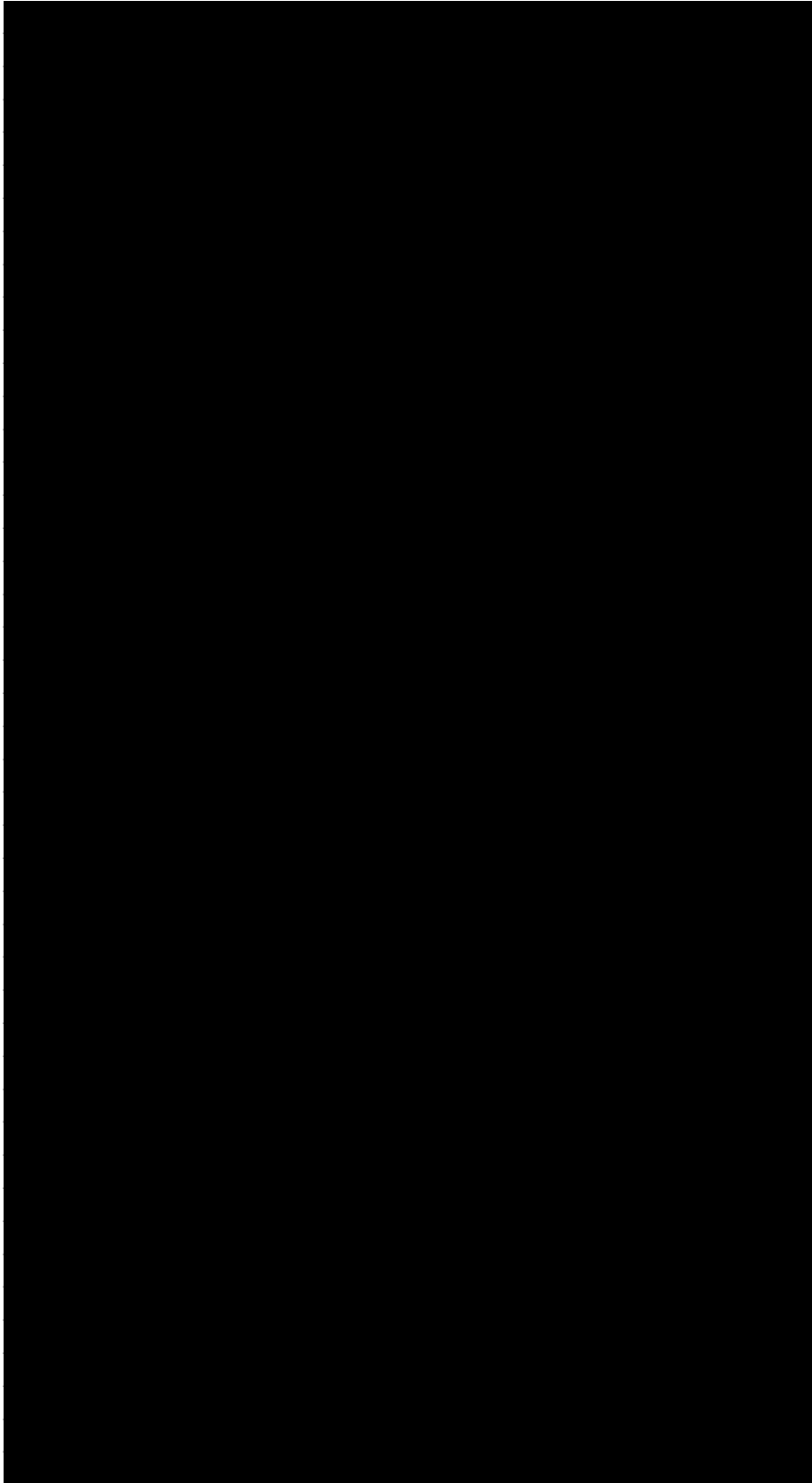


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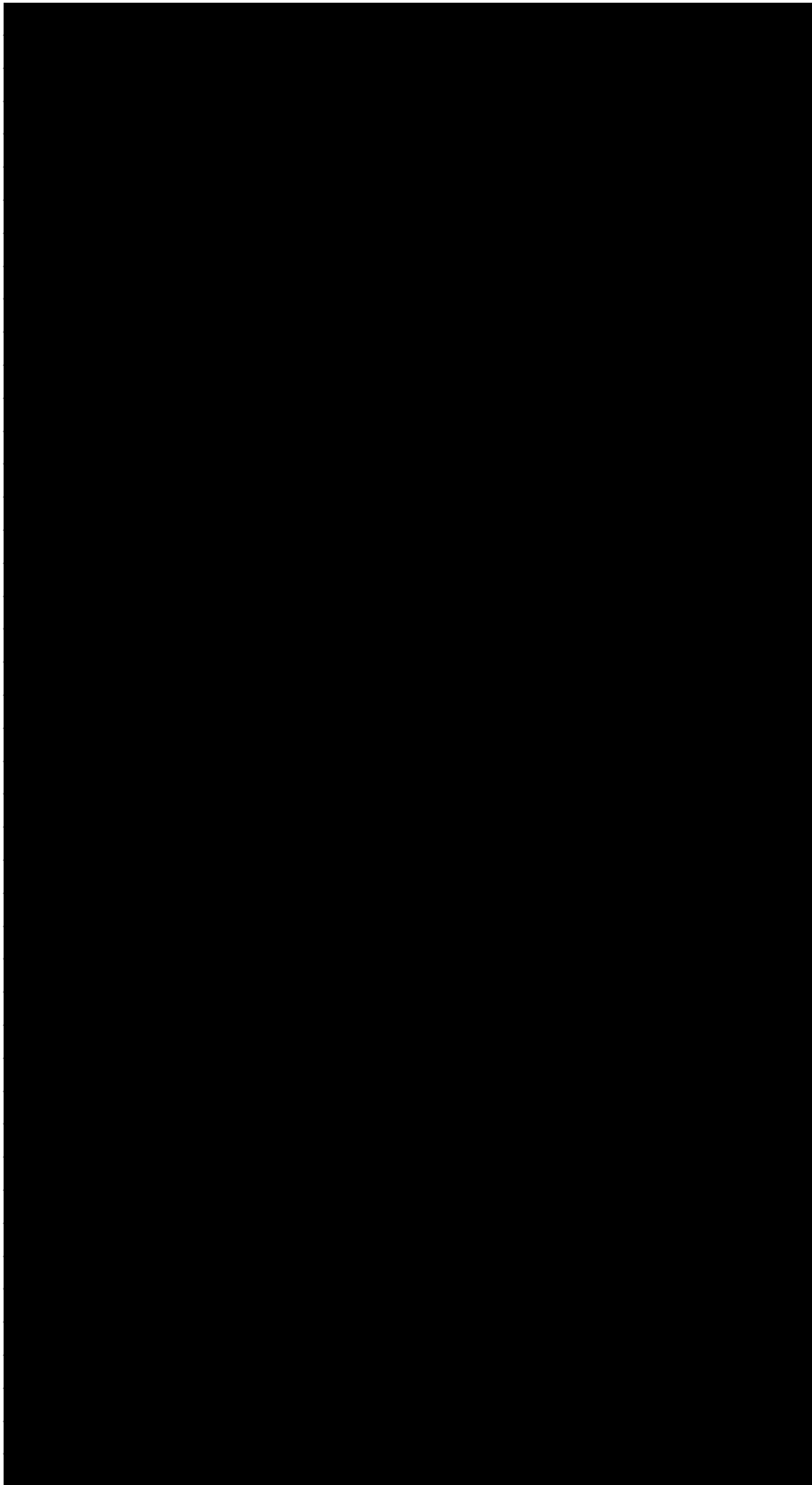




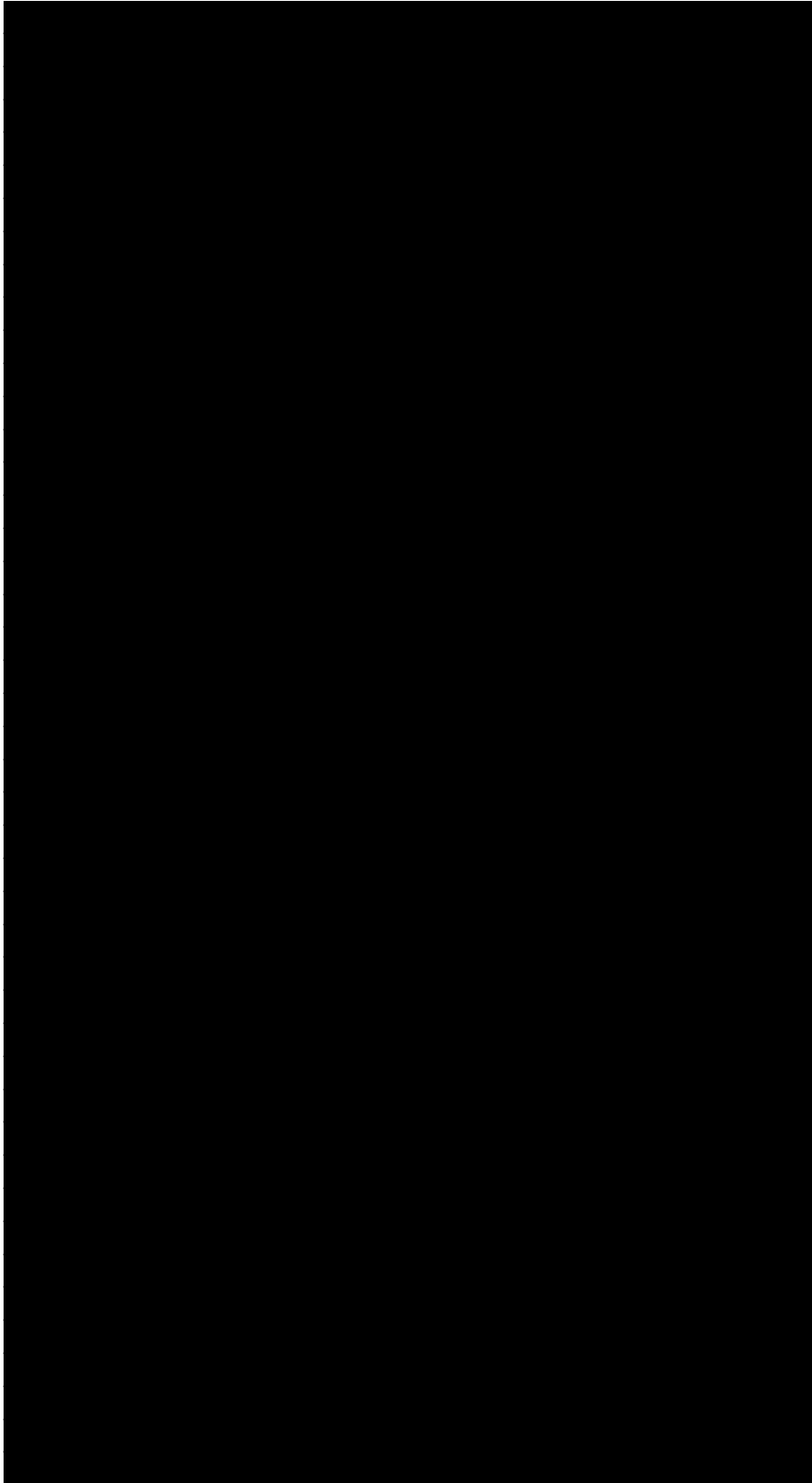
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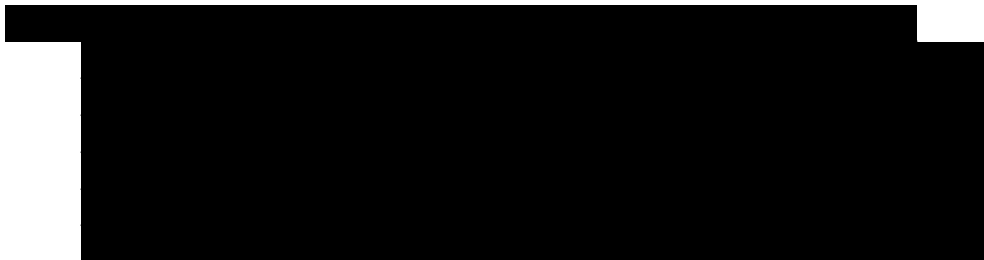
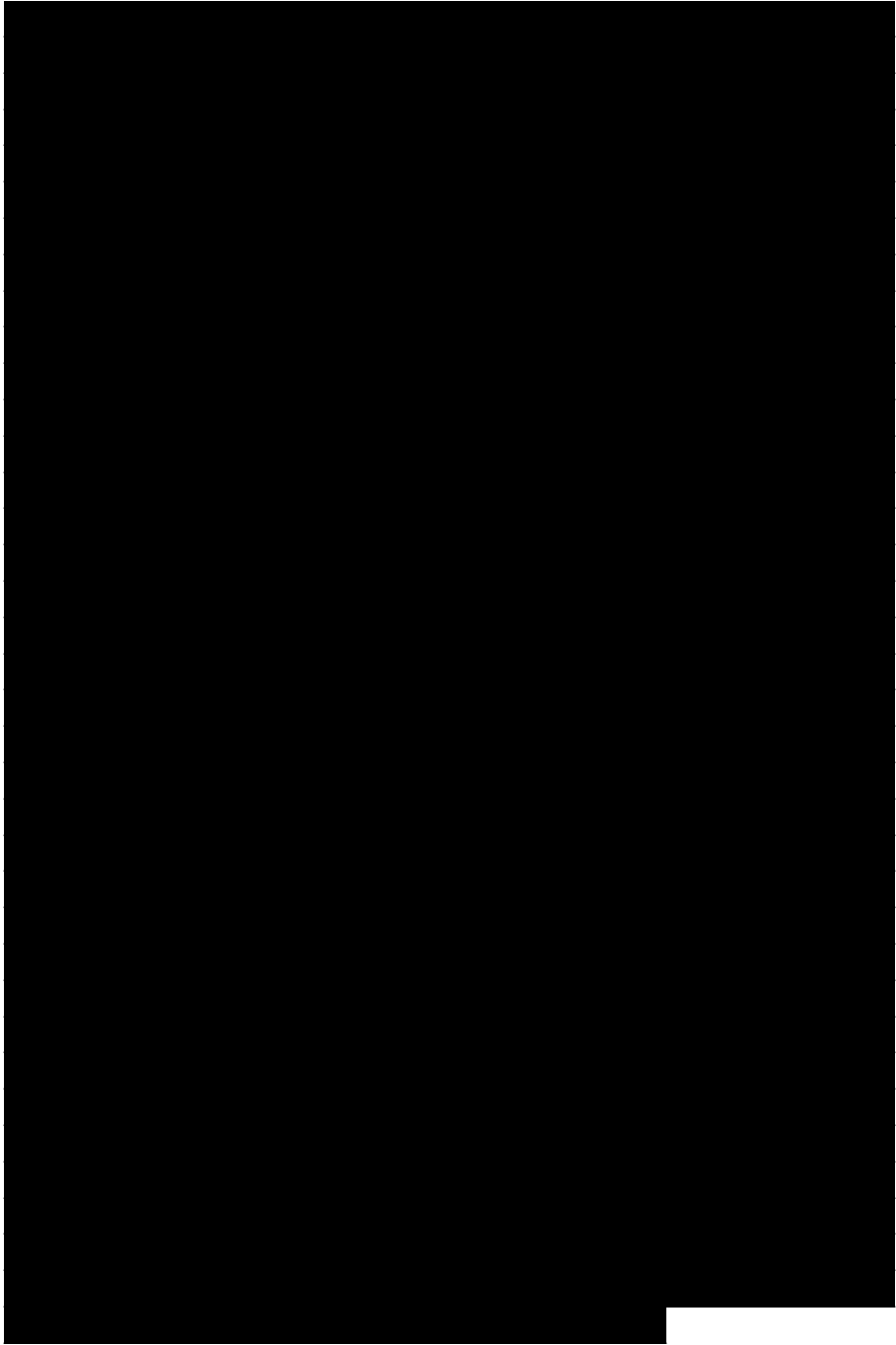
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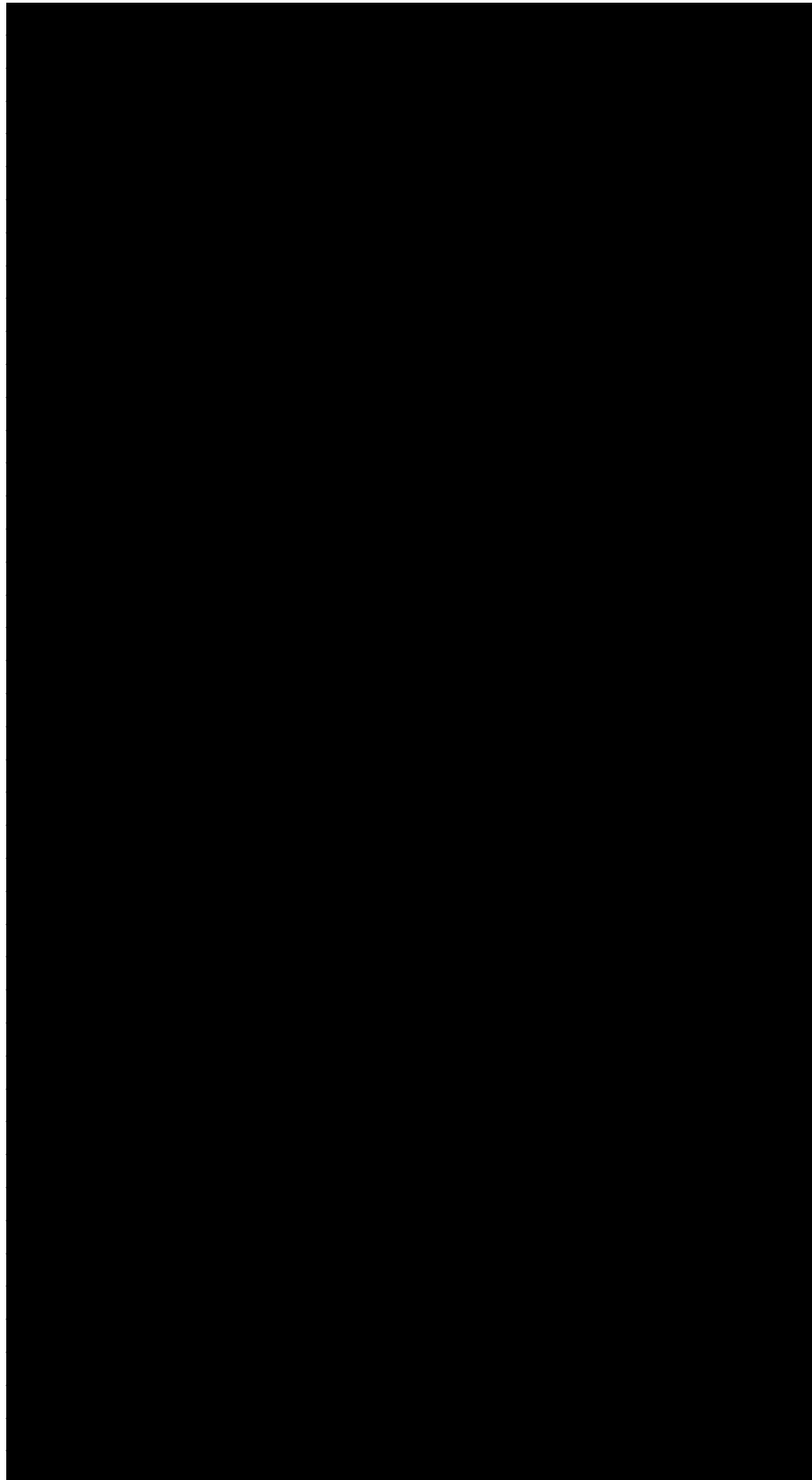
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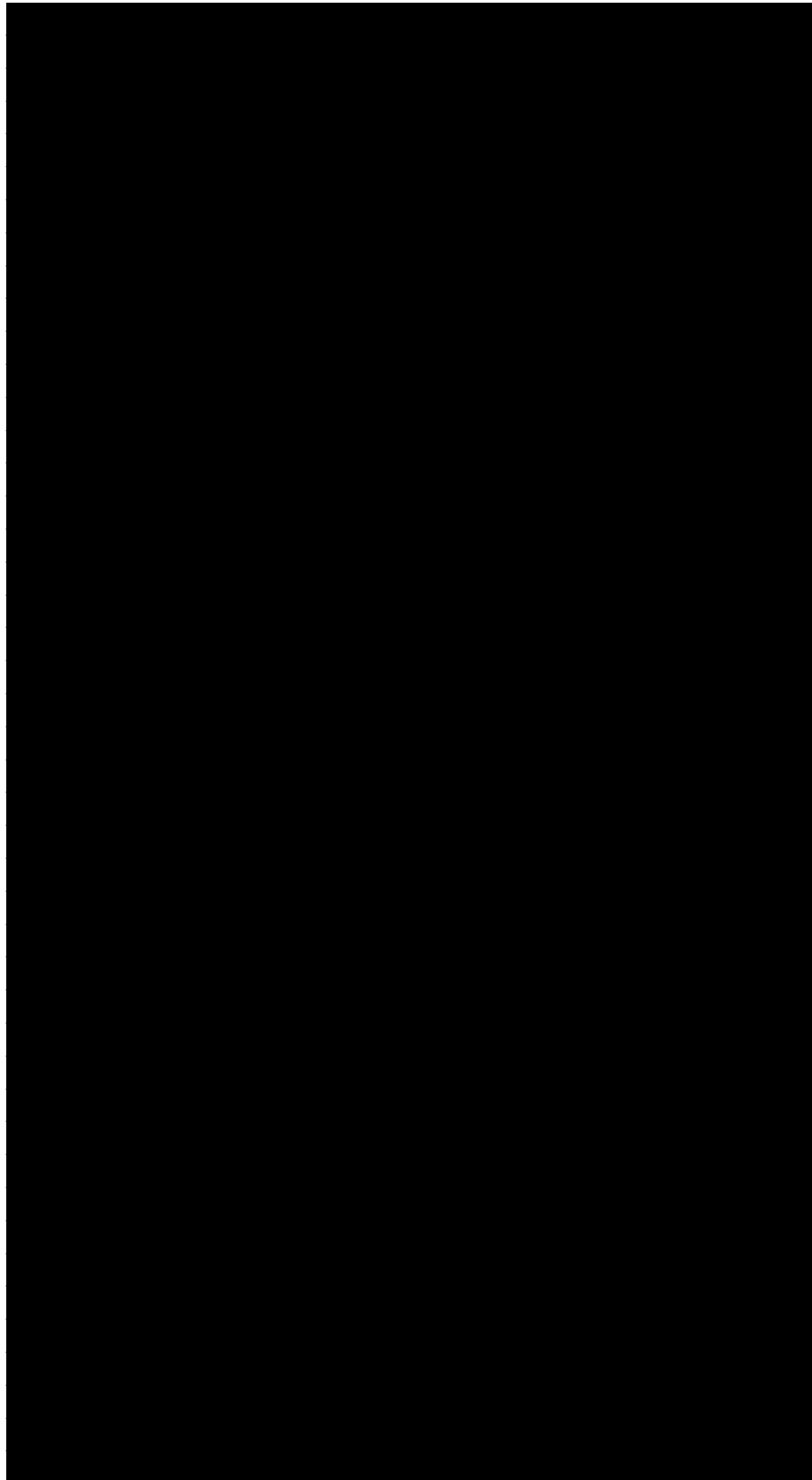
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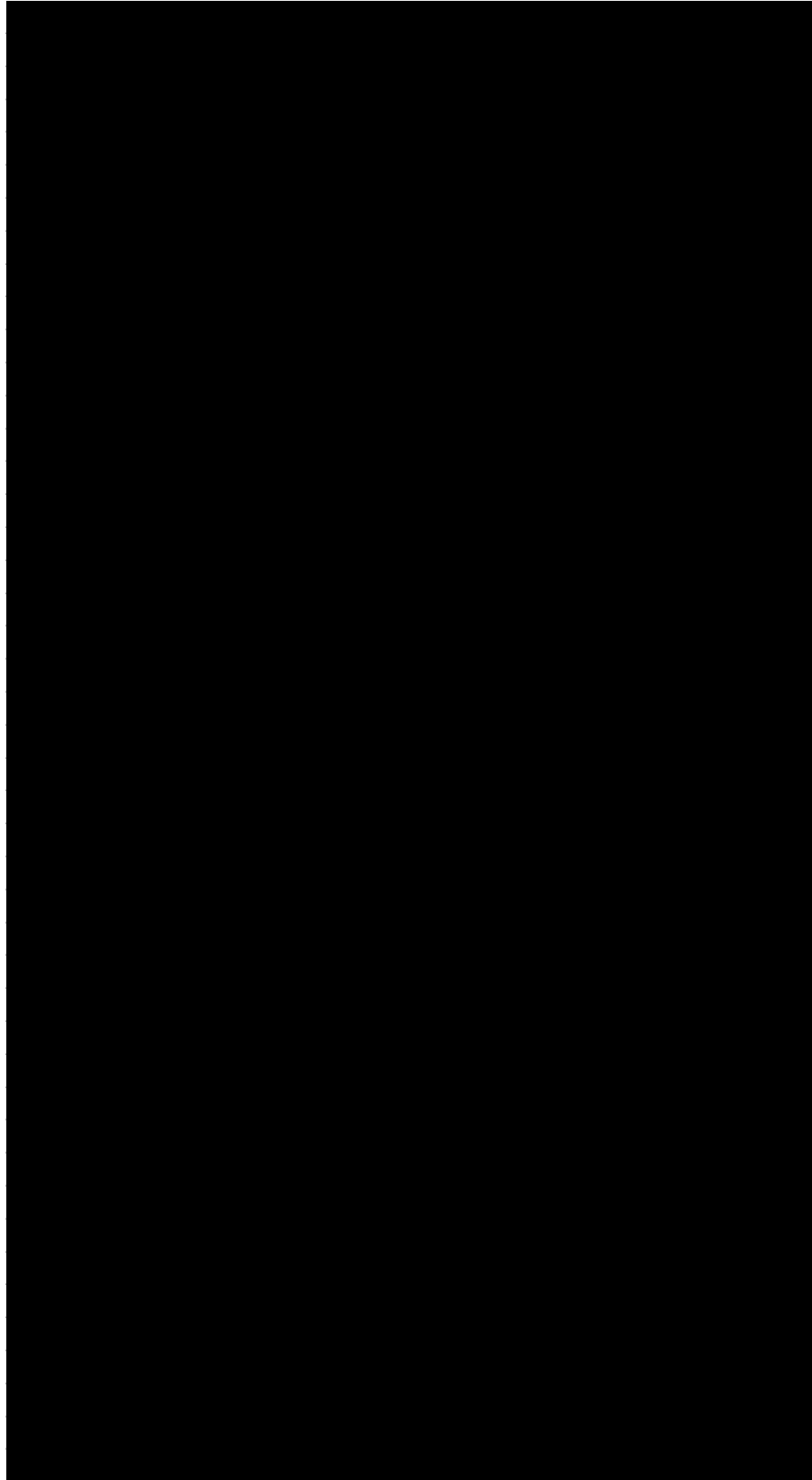
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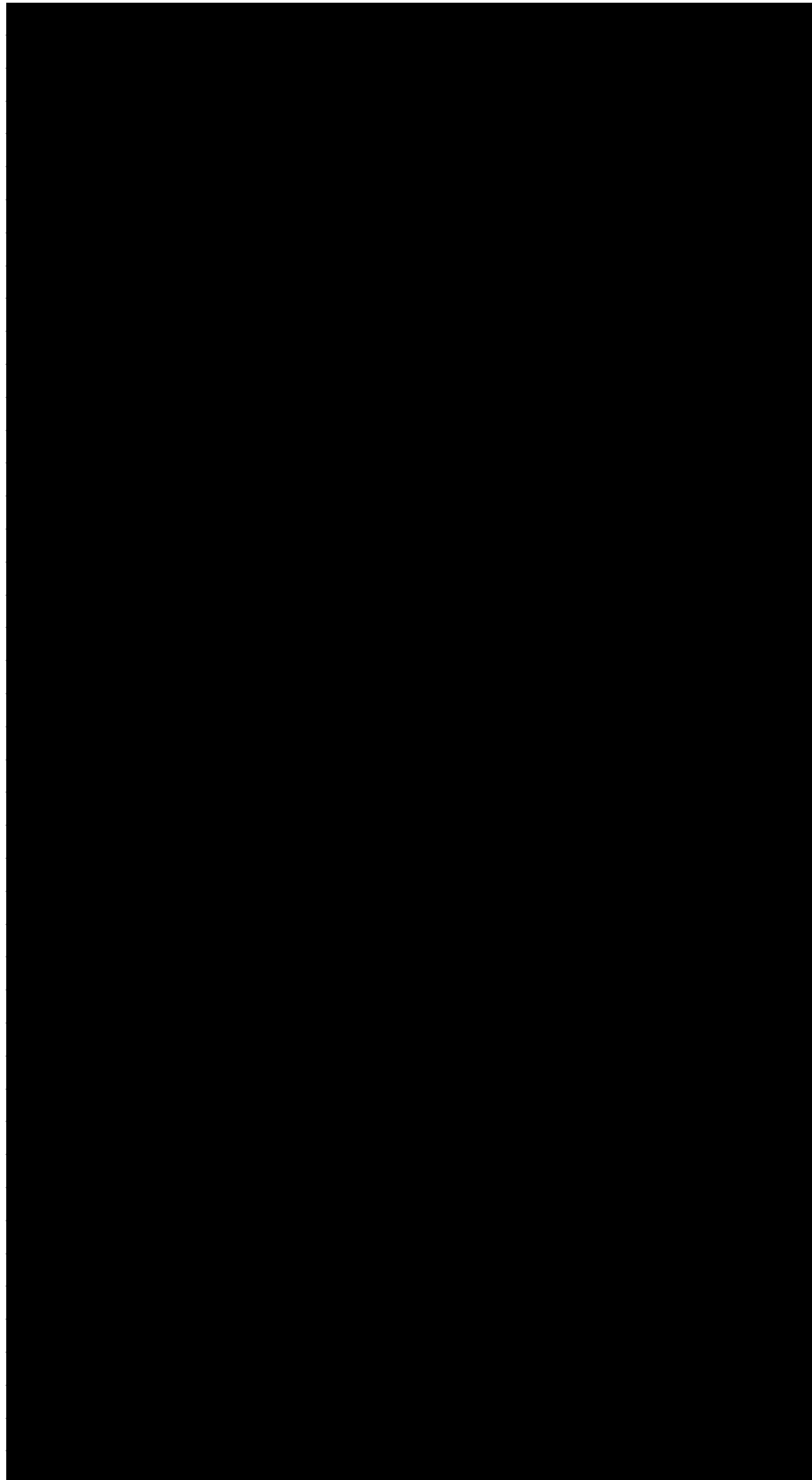
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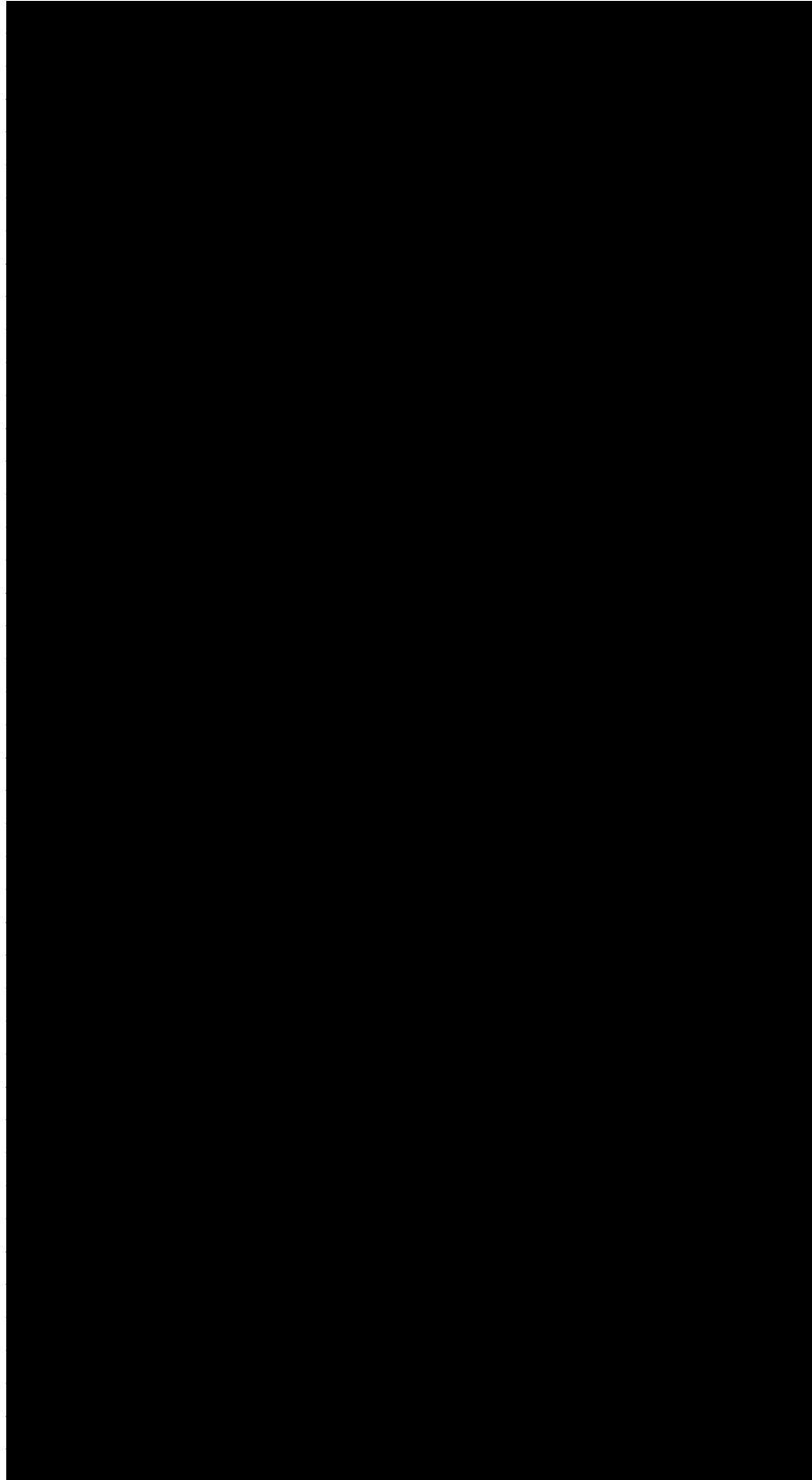
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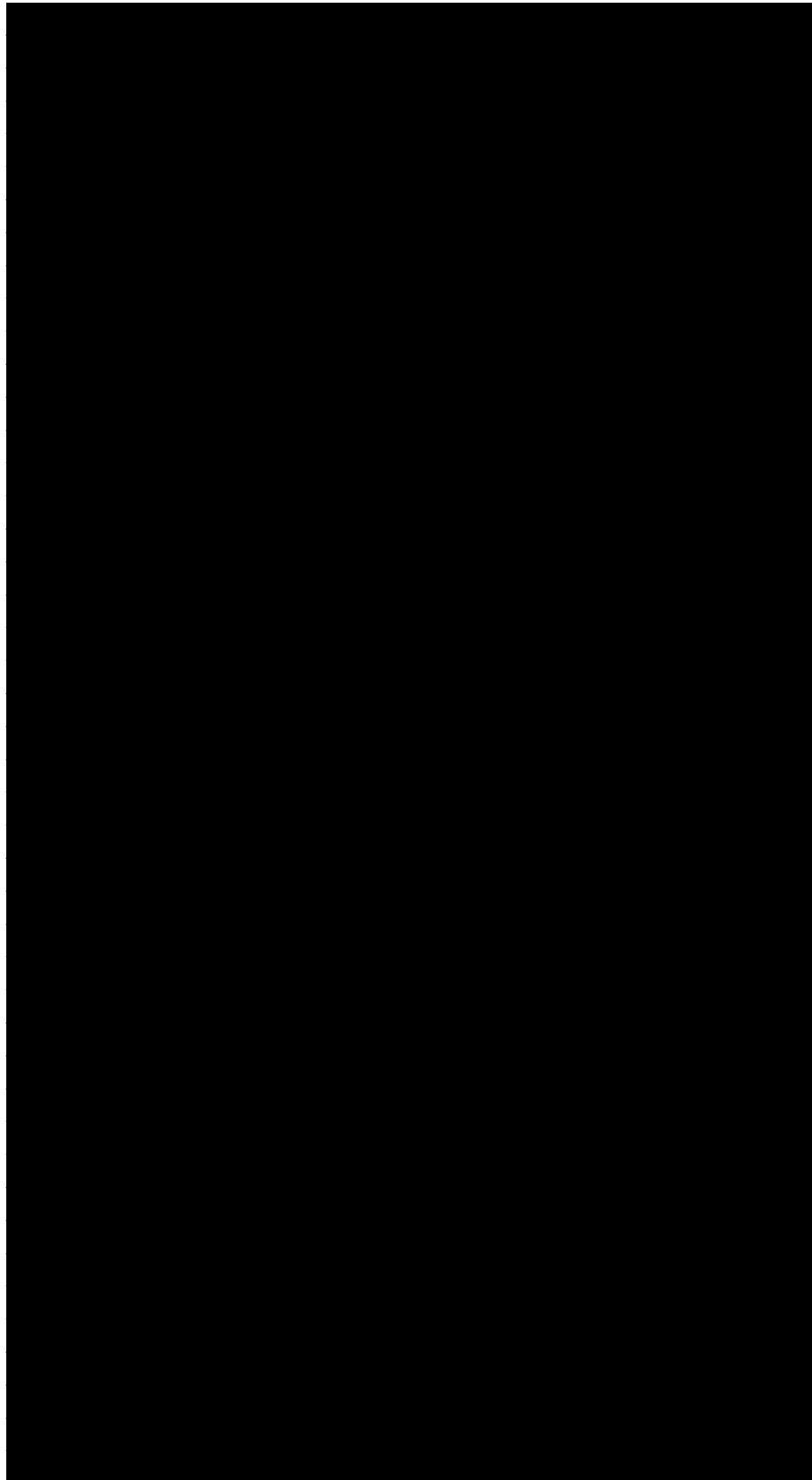
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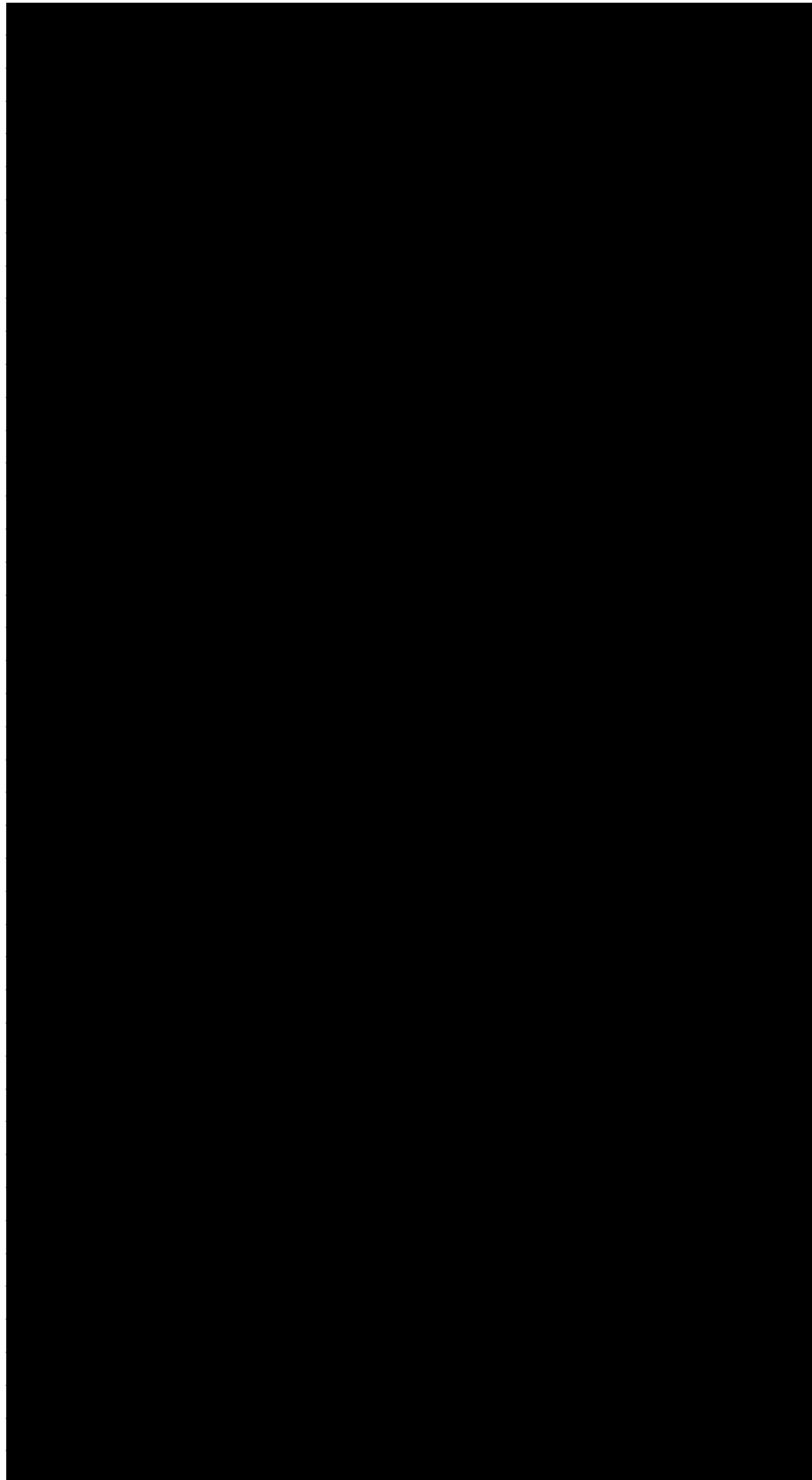
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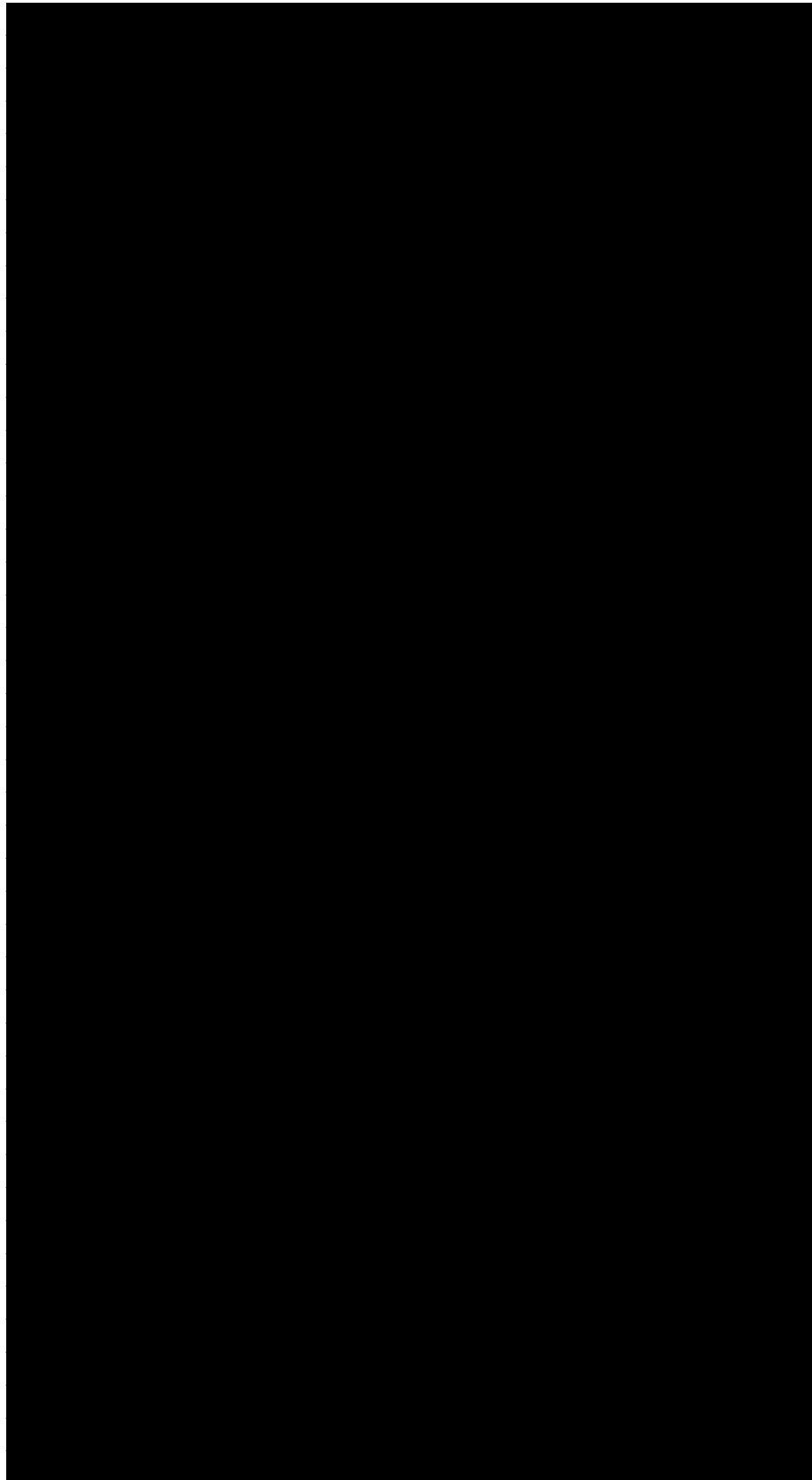
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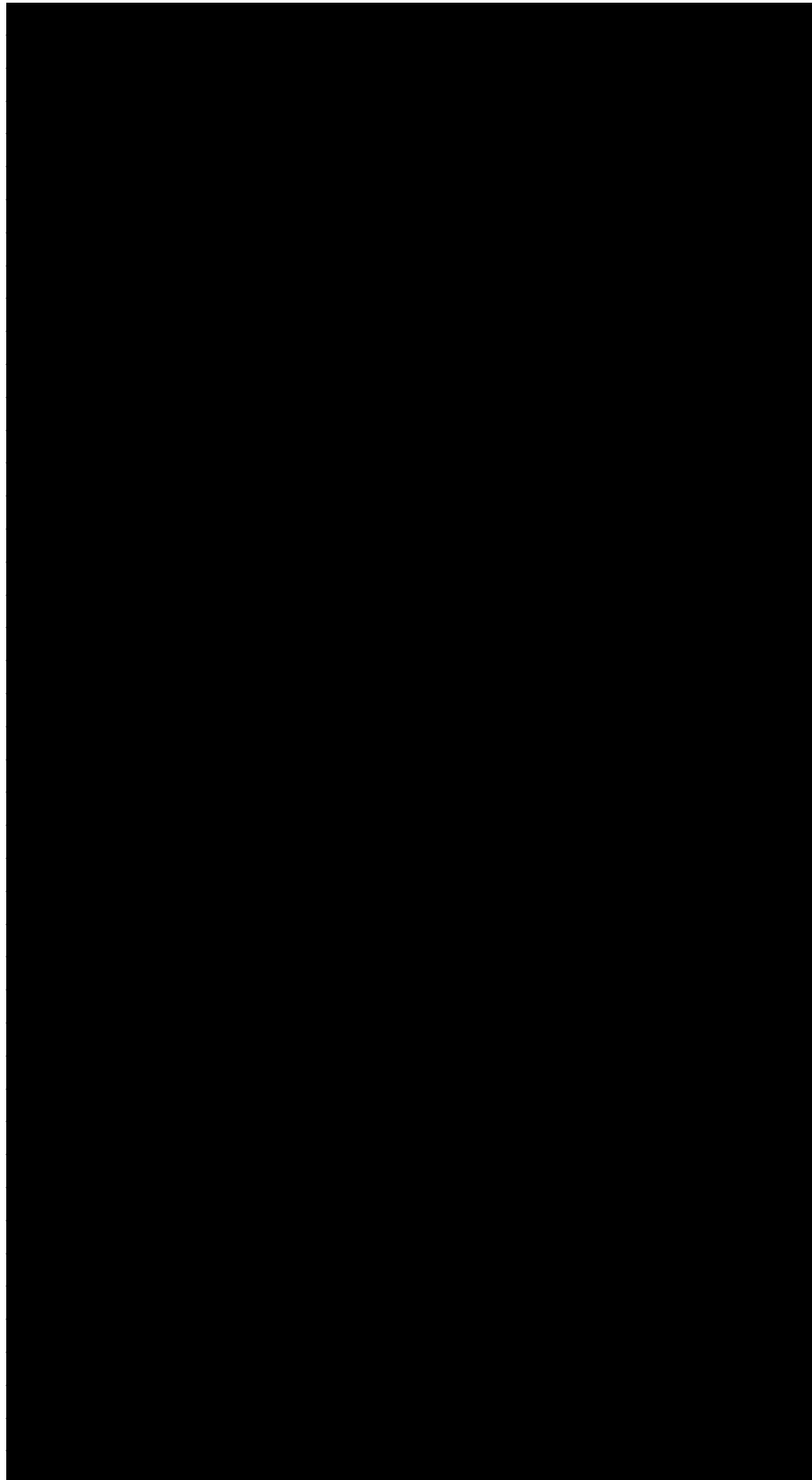
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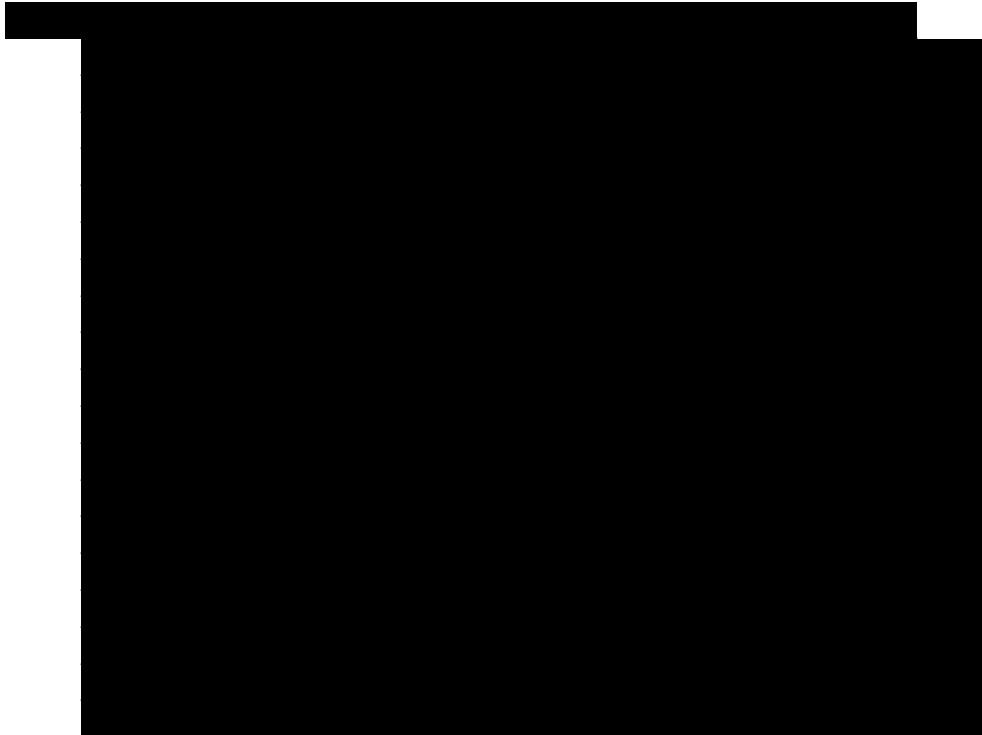
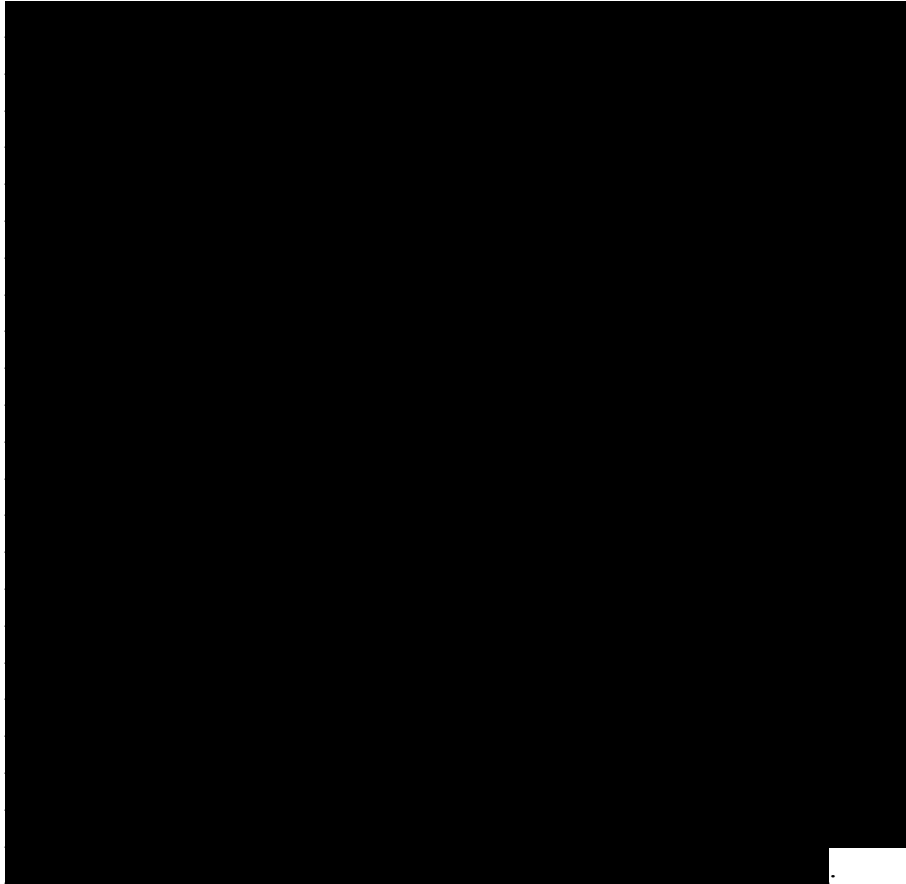
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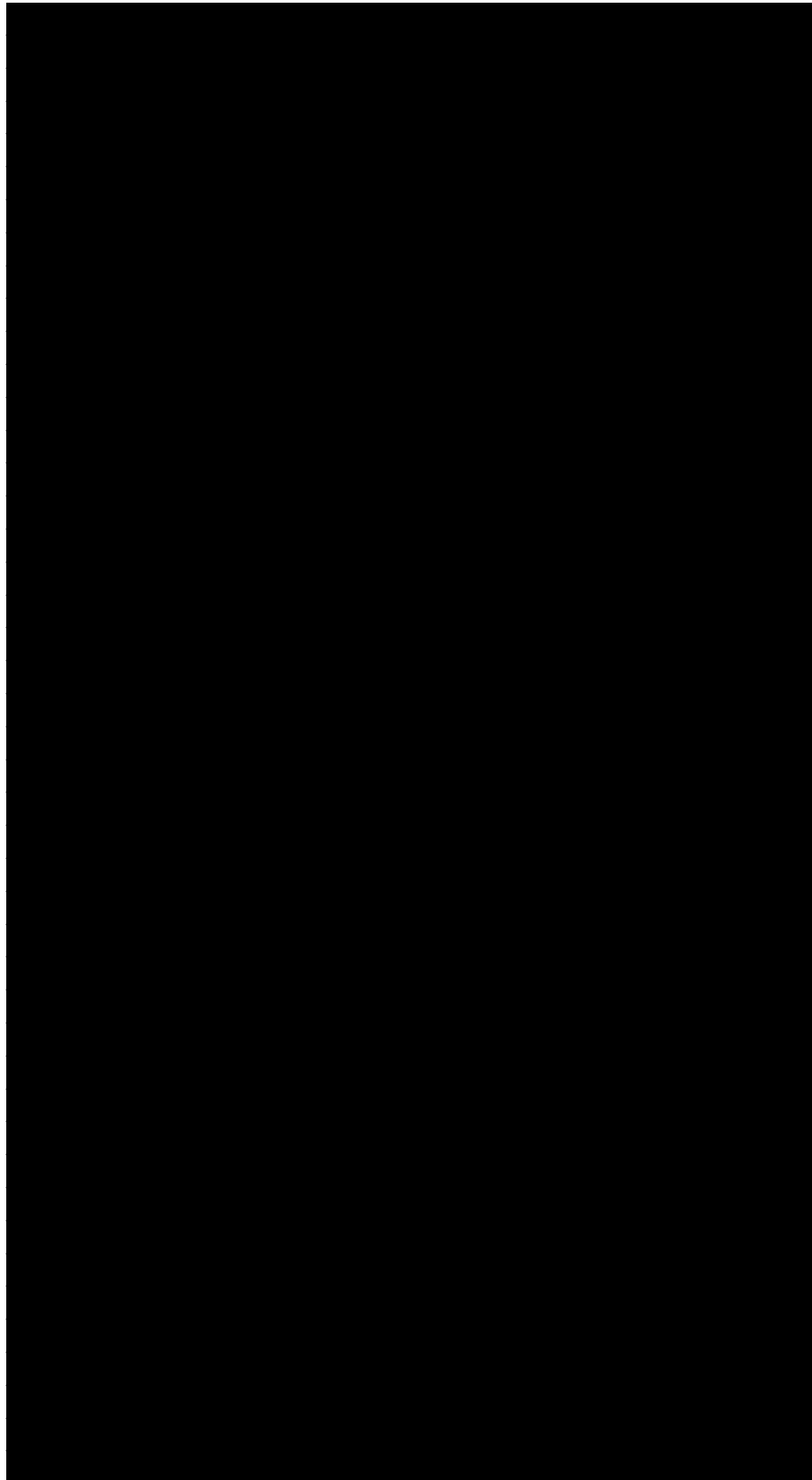
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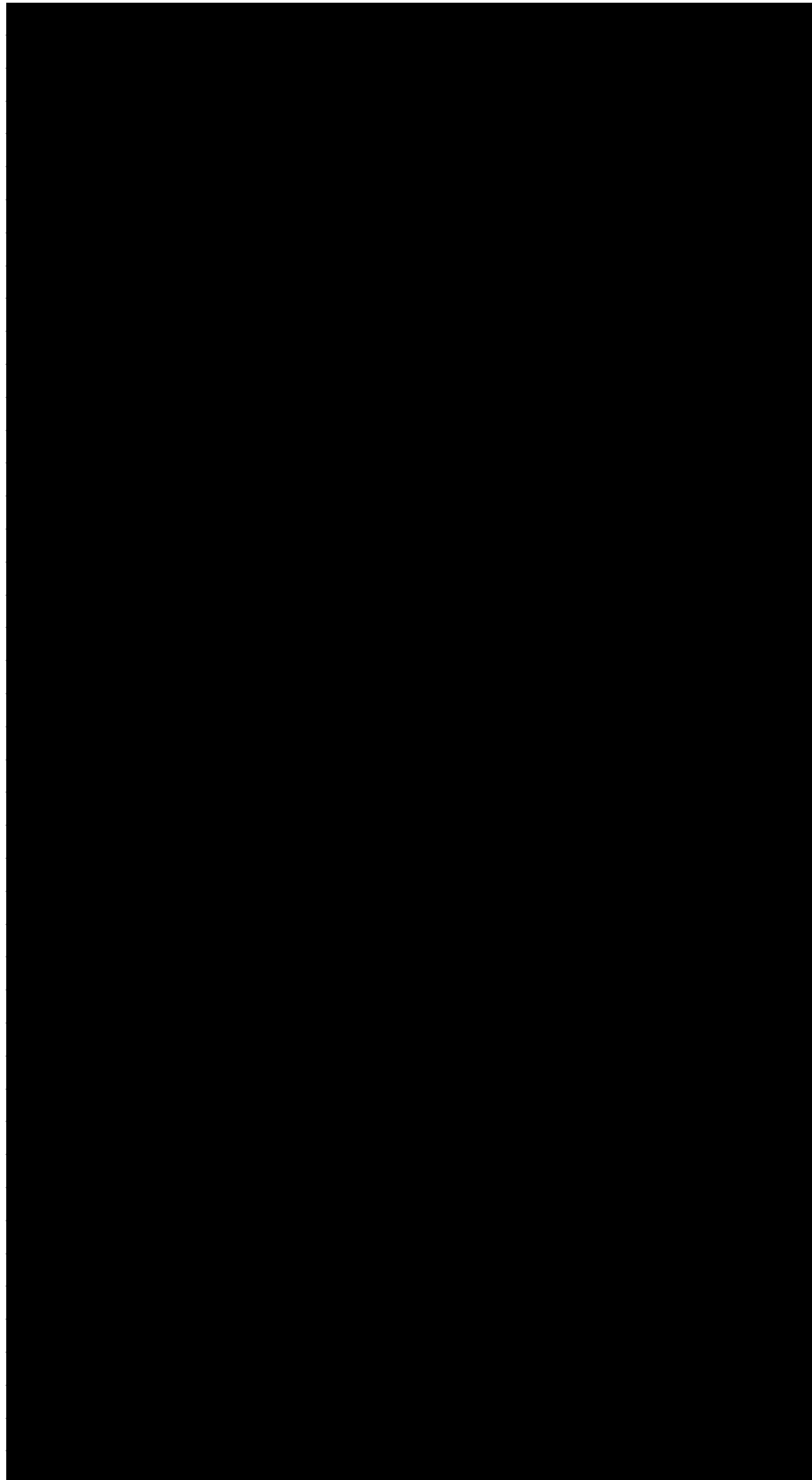
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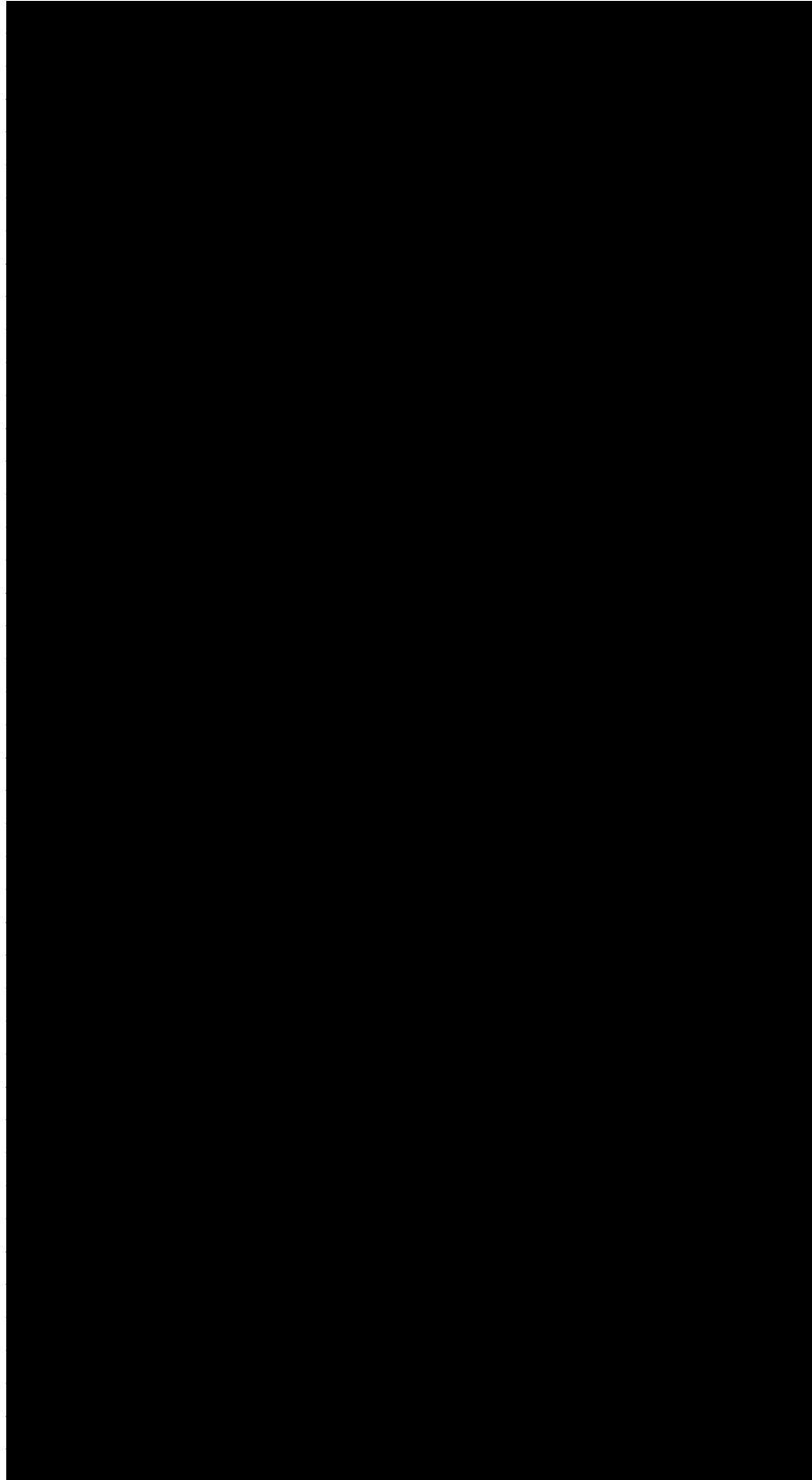
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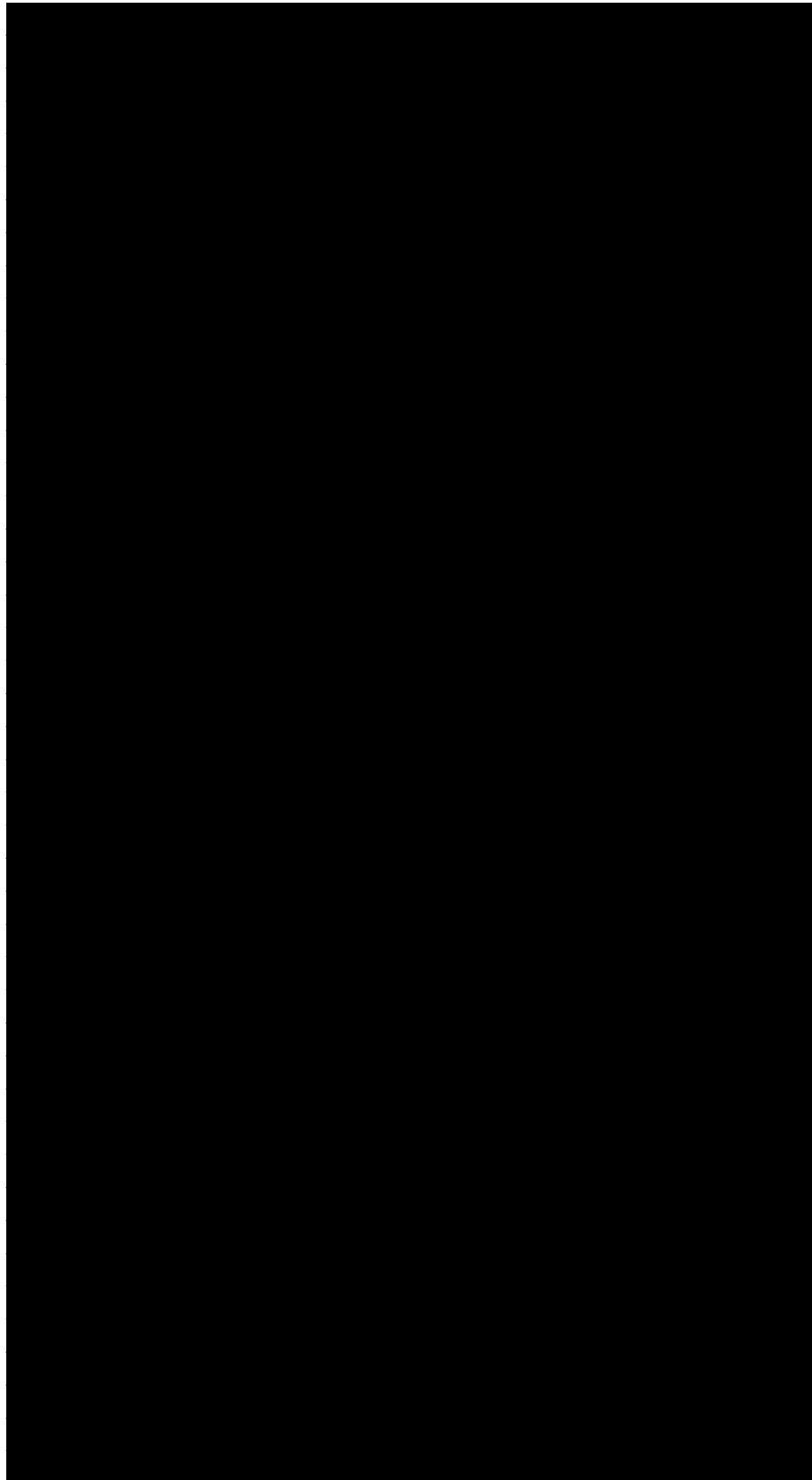
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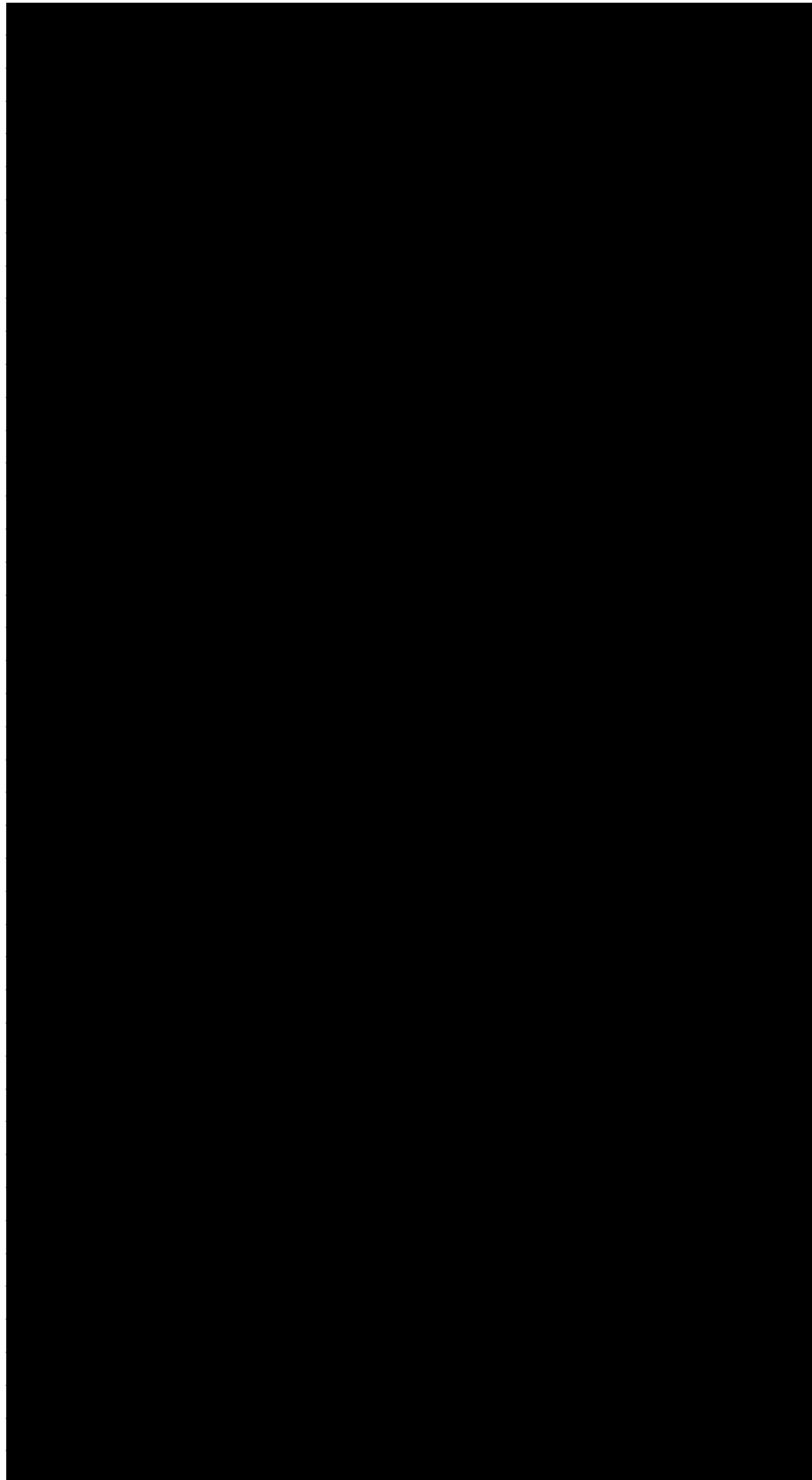
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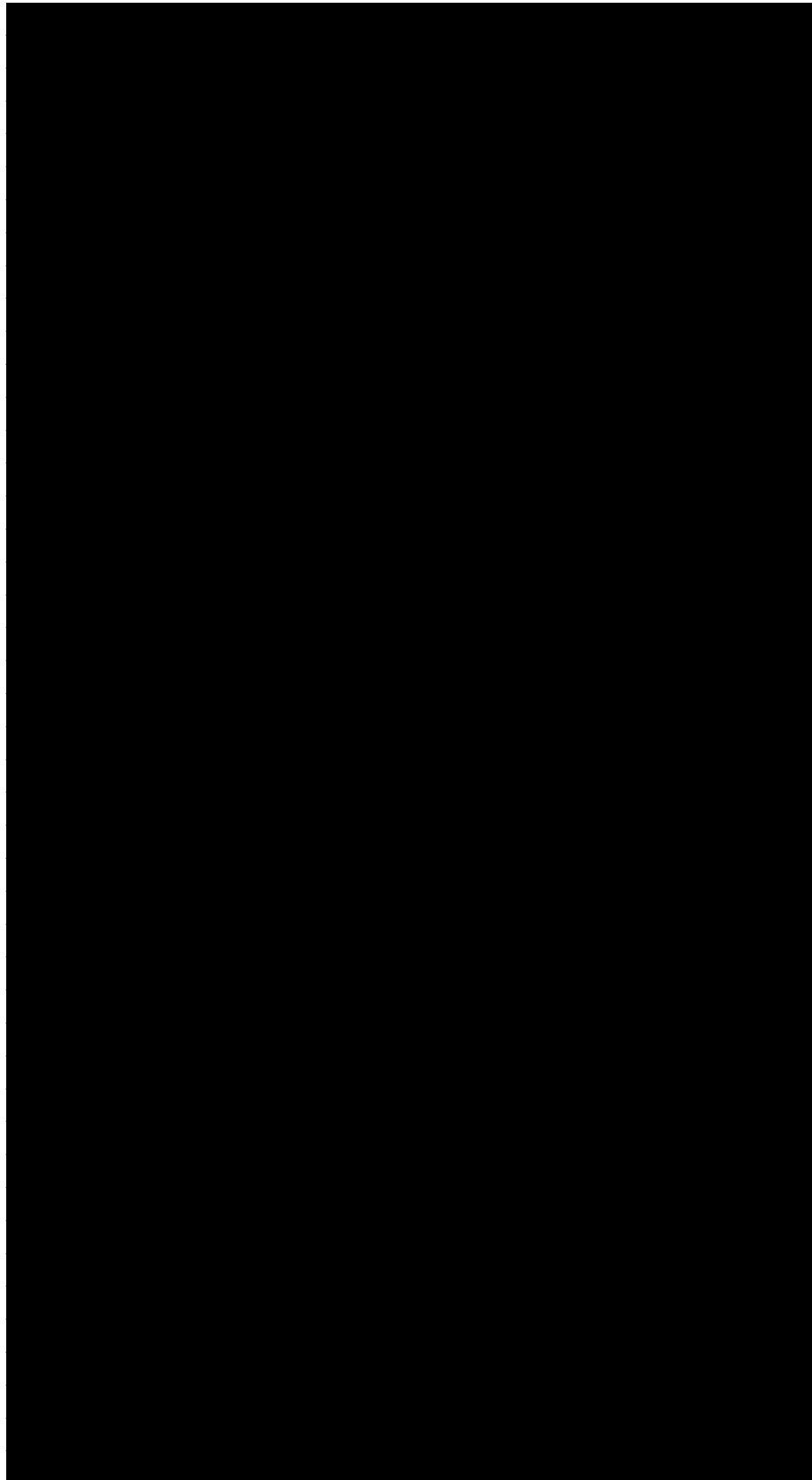
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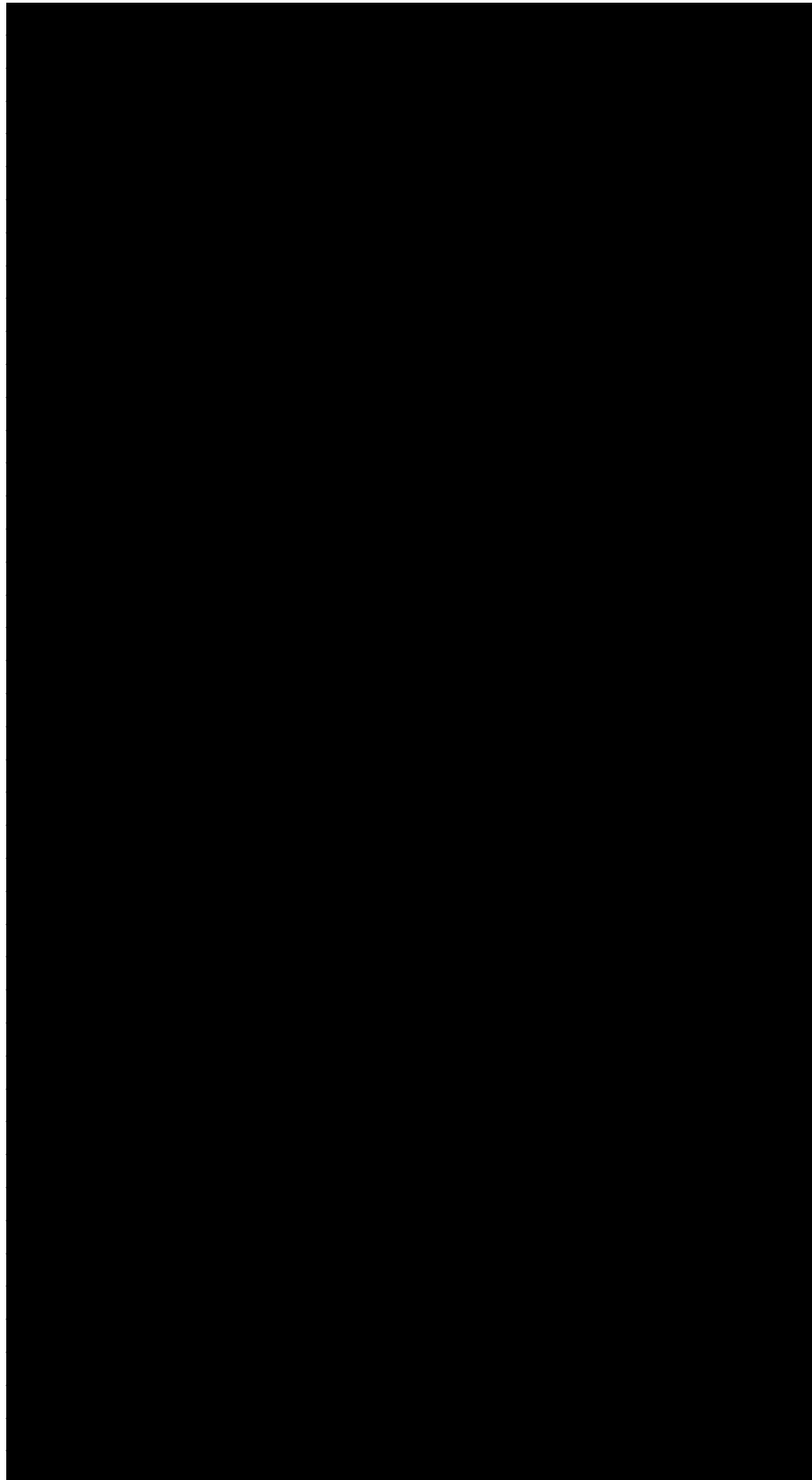
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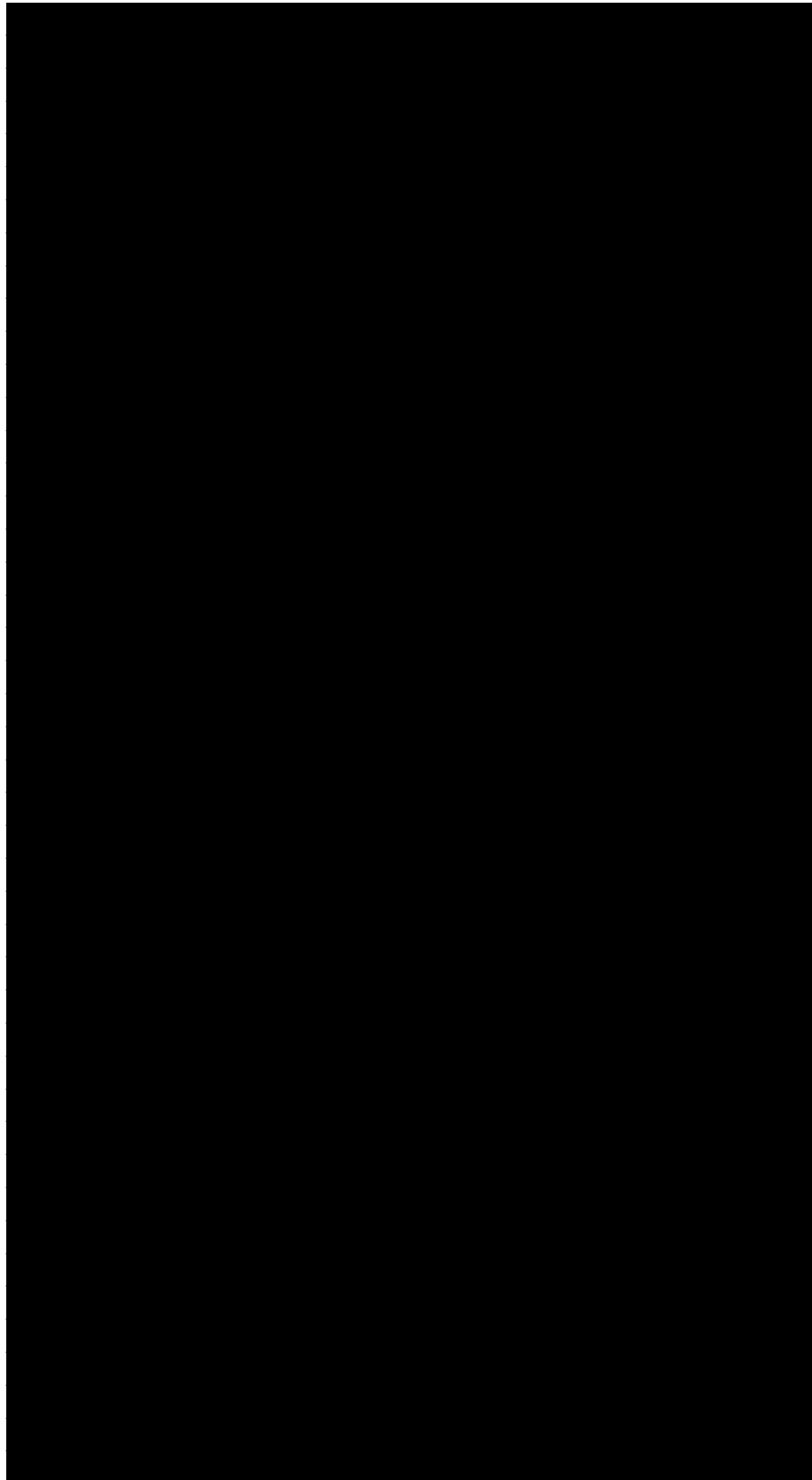
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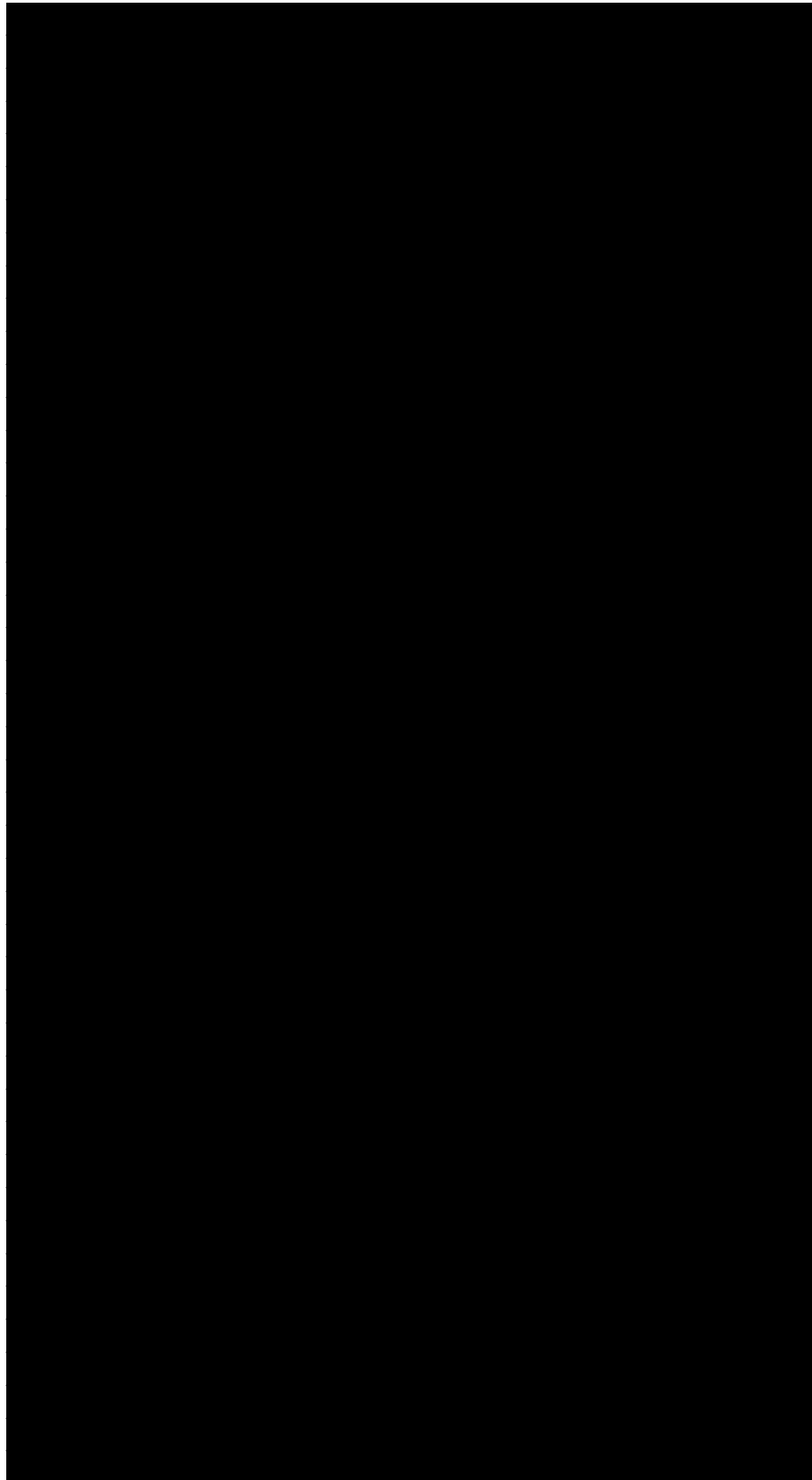
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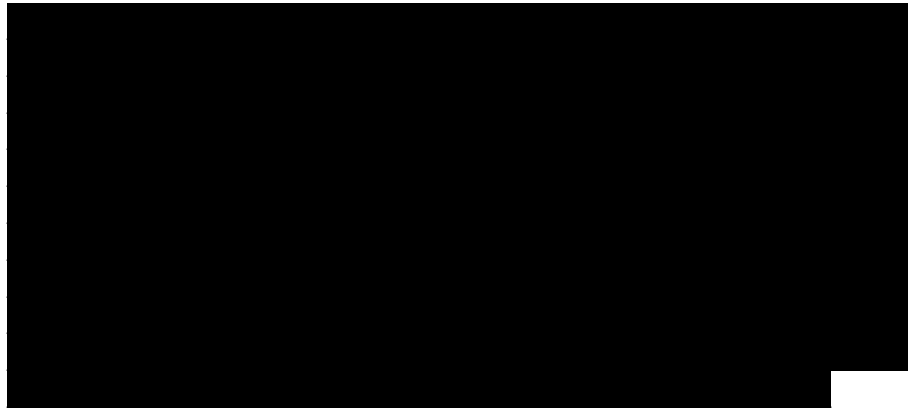


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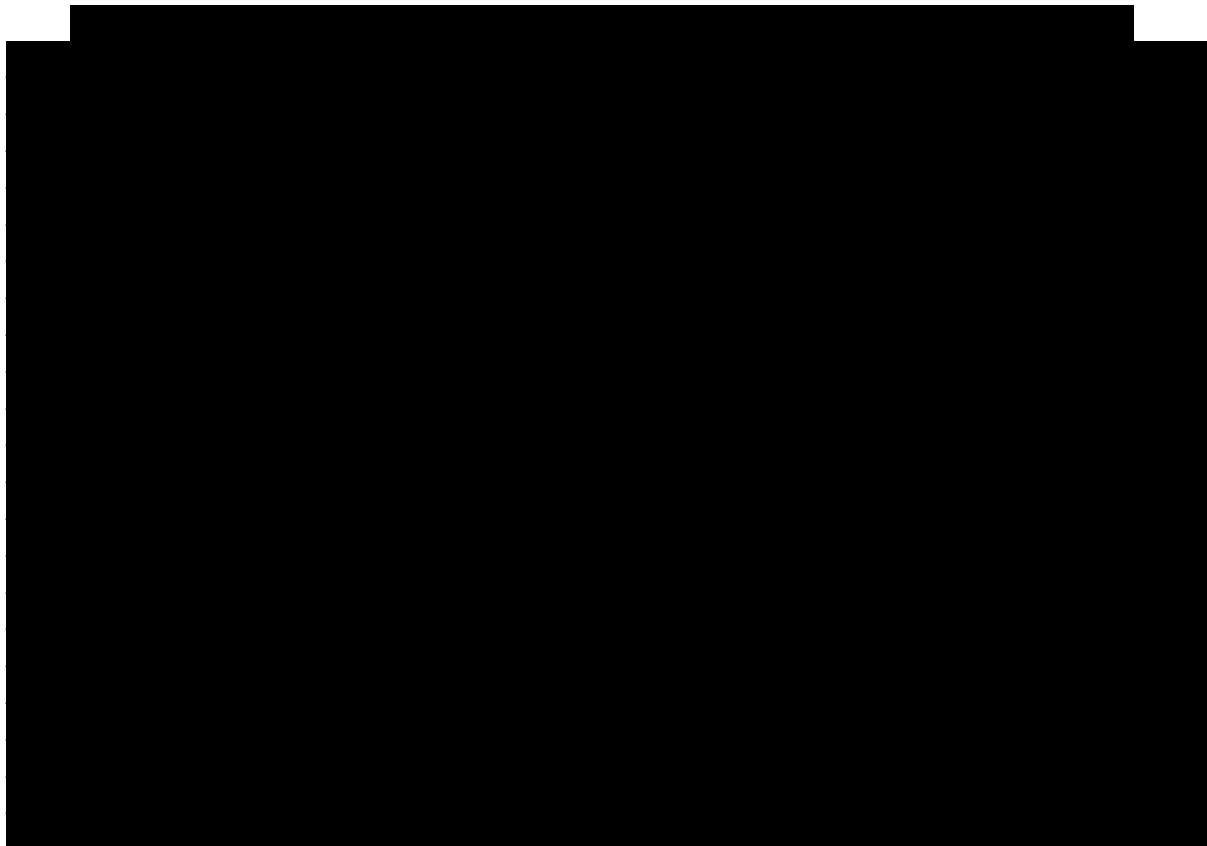


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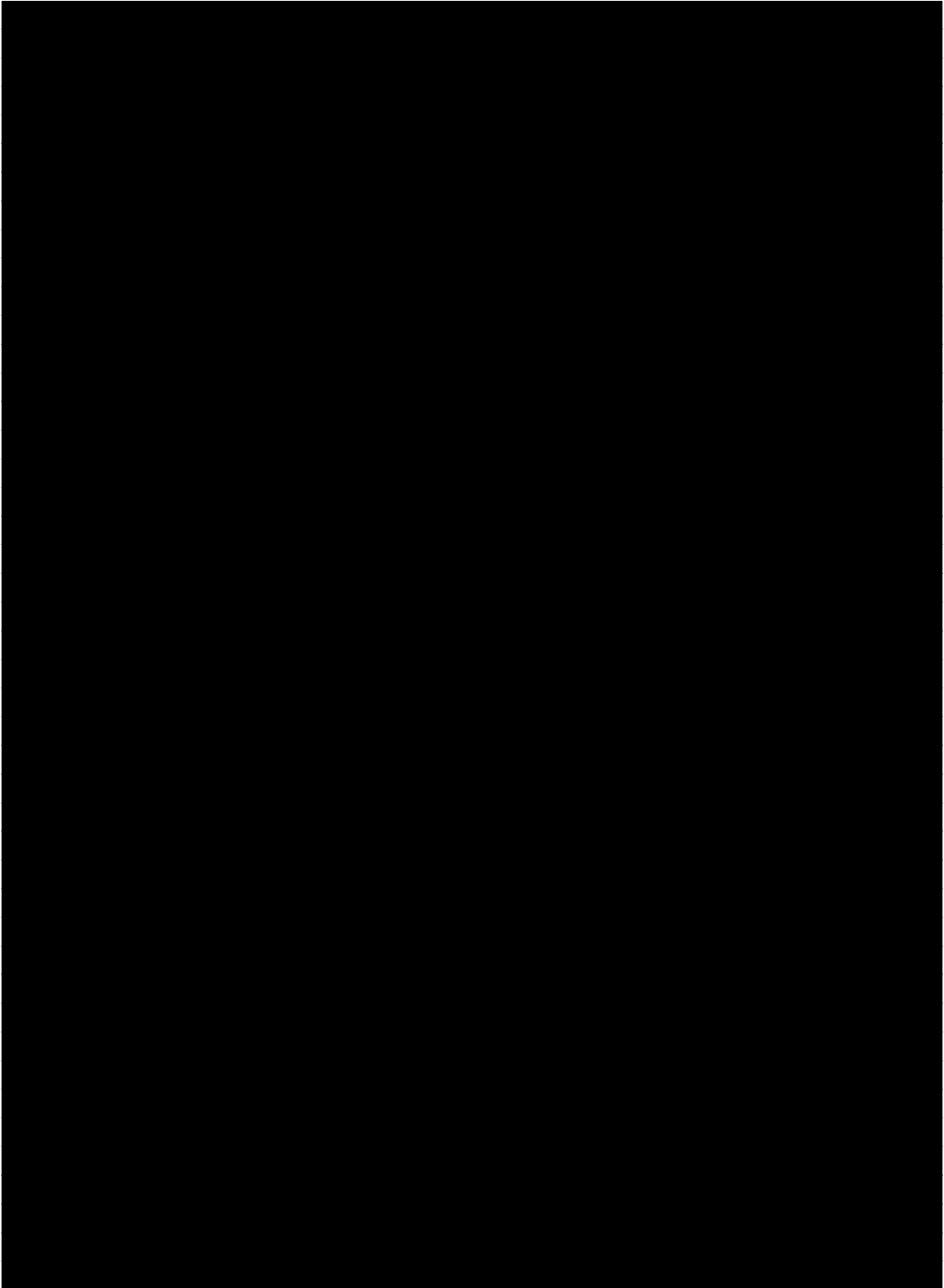


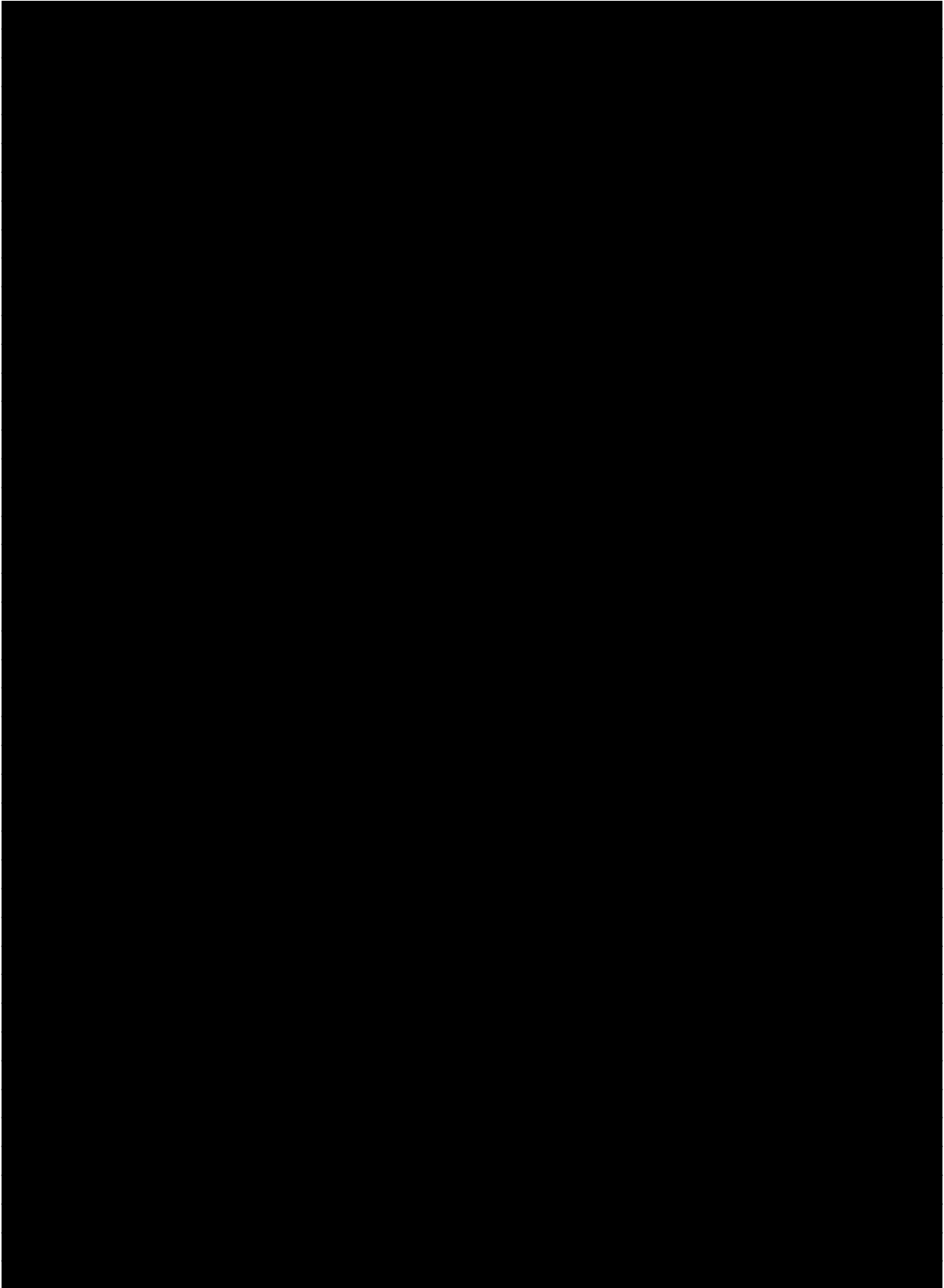


- (i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and
 - (ii) Consult with the requesting provider when appropriate.
- (3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease....

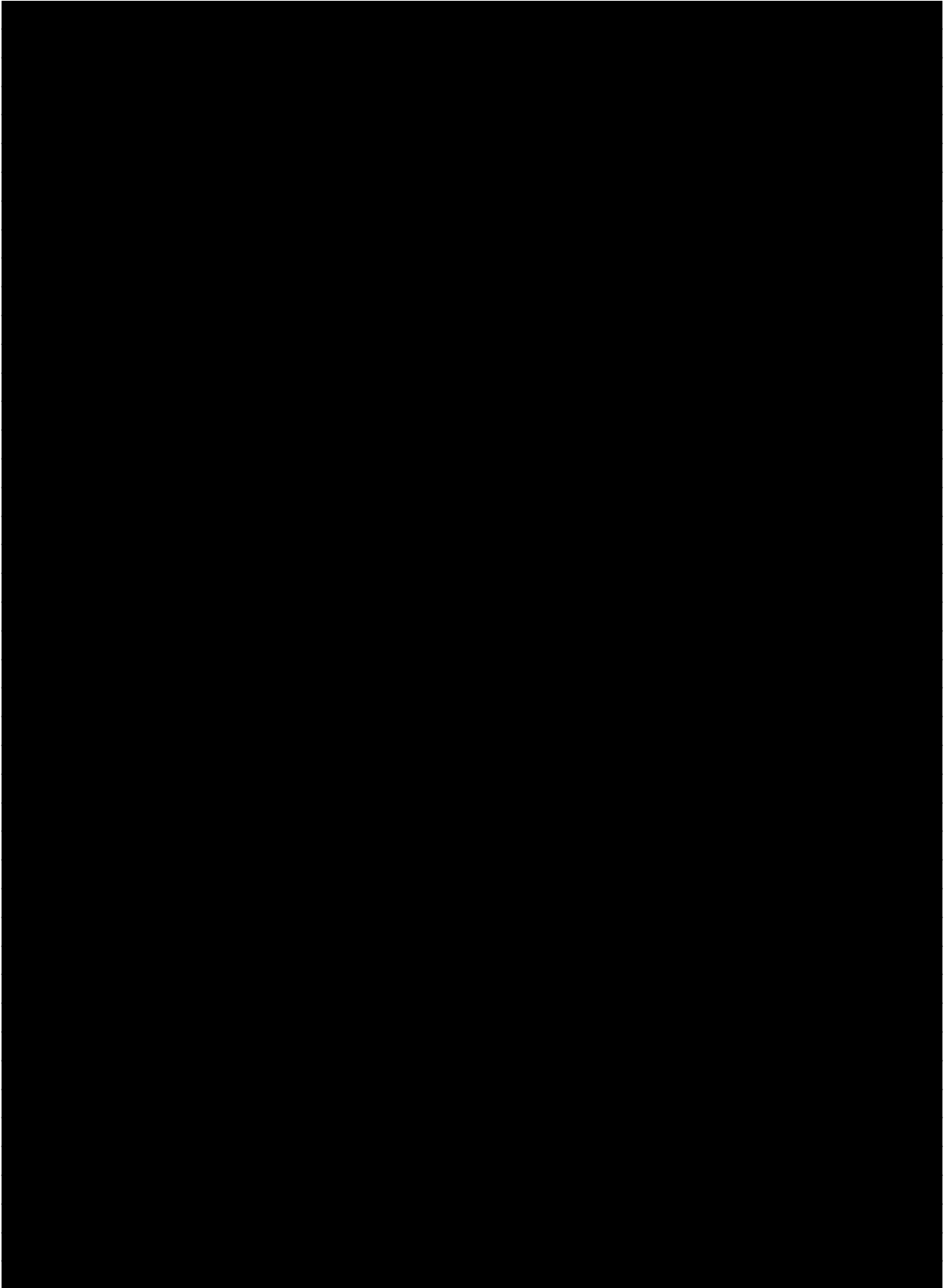


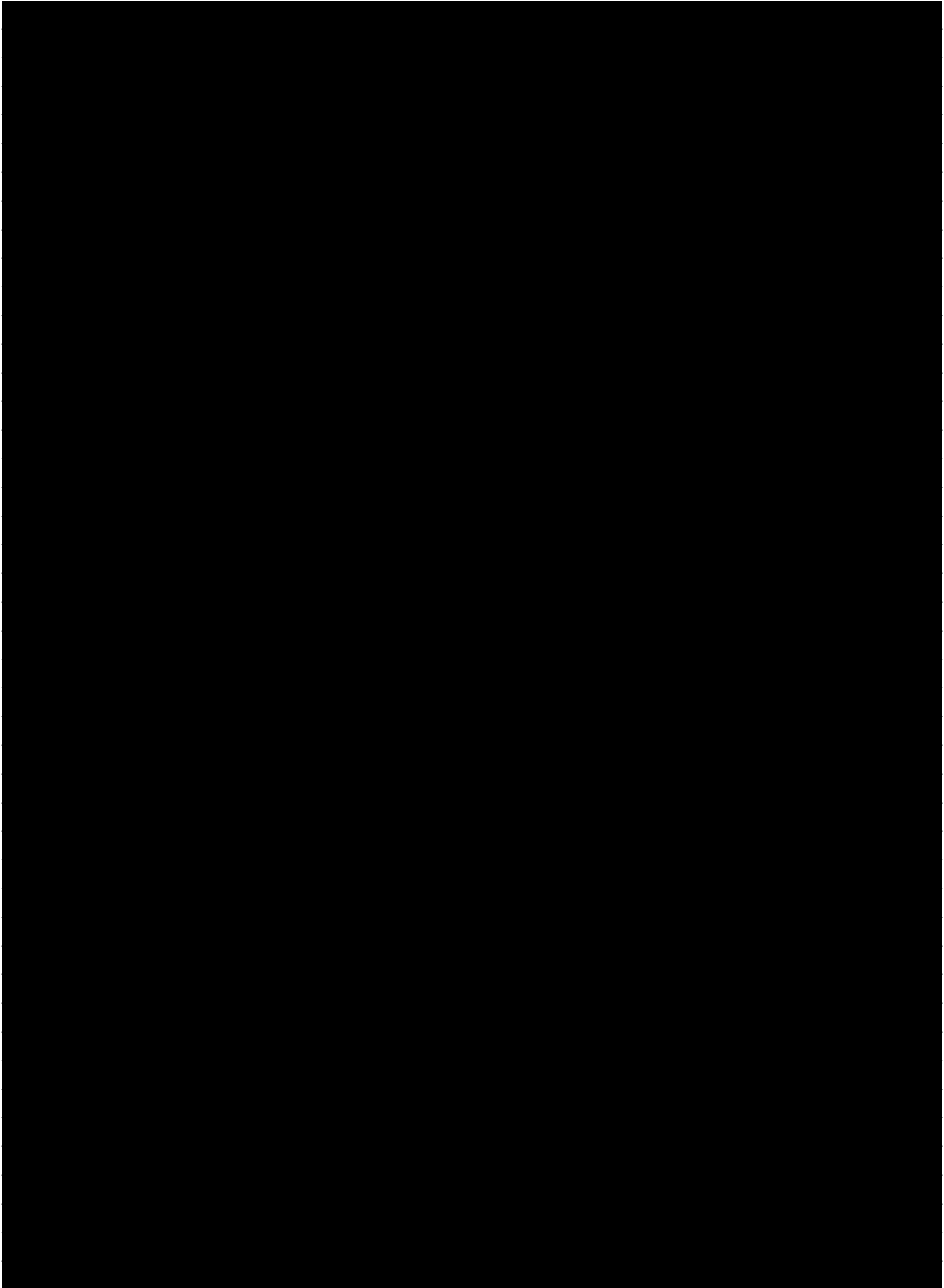
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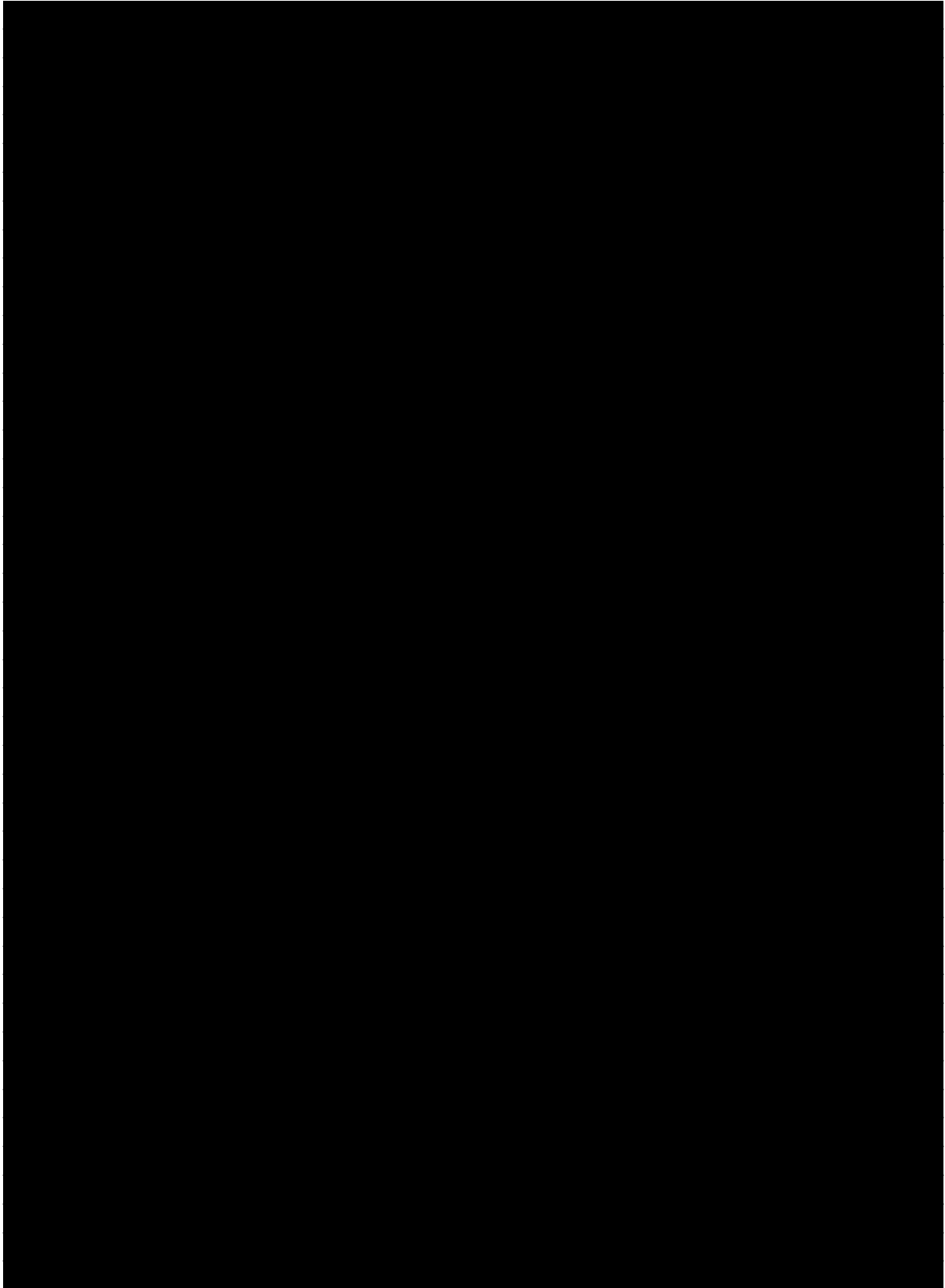


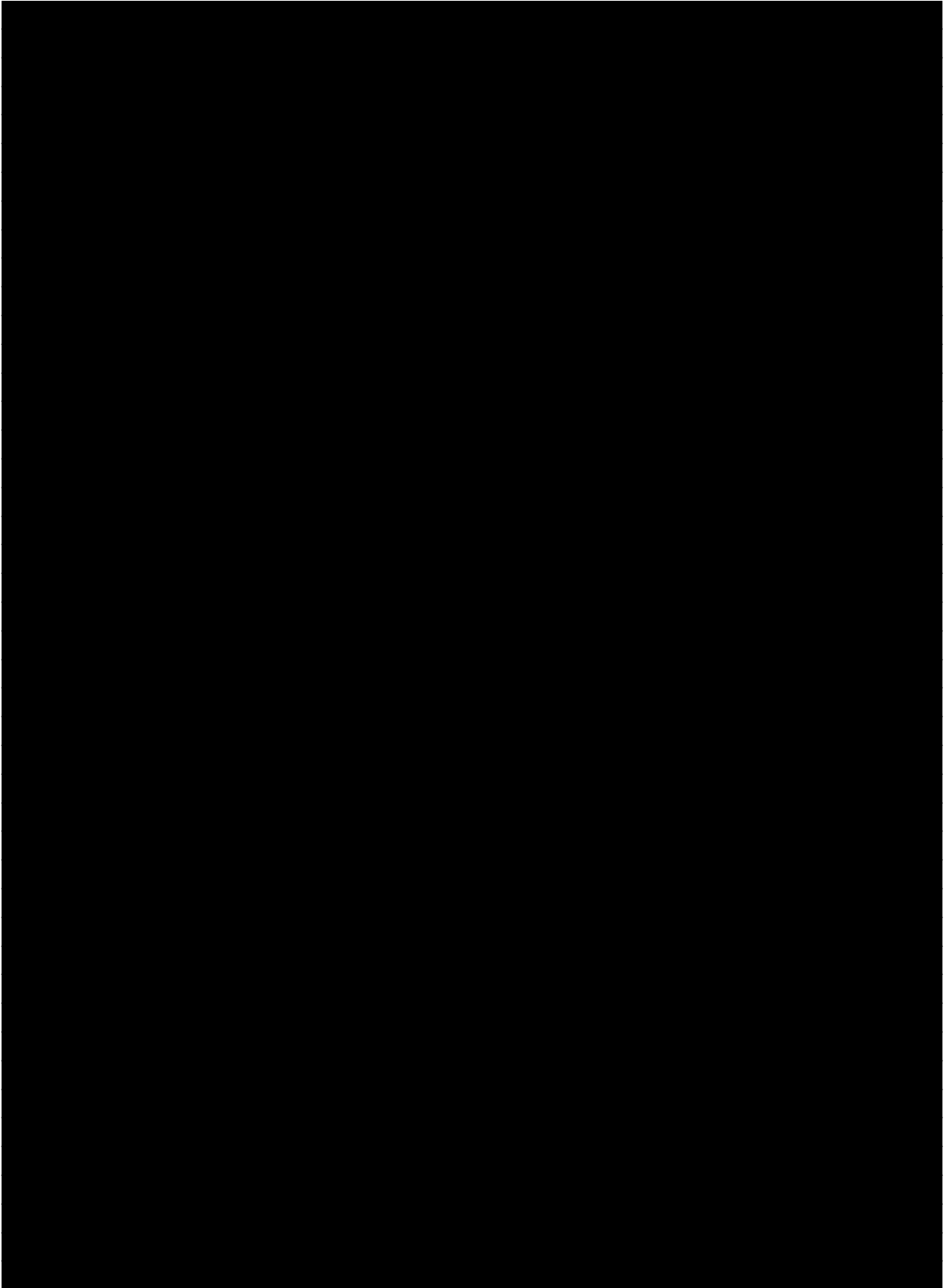
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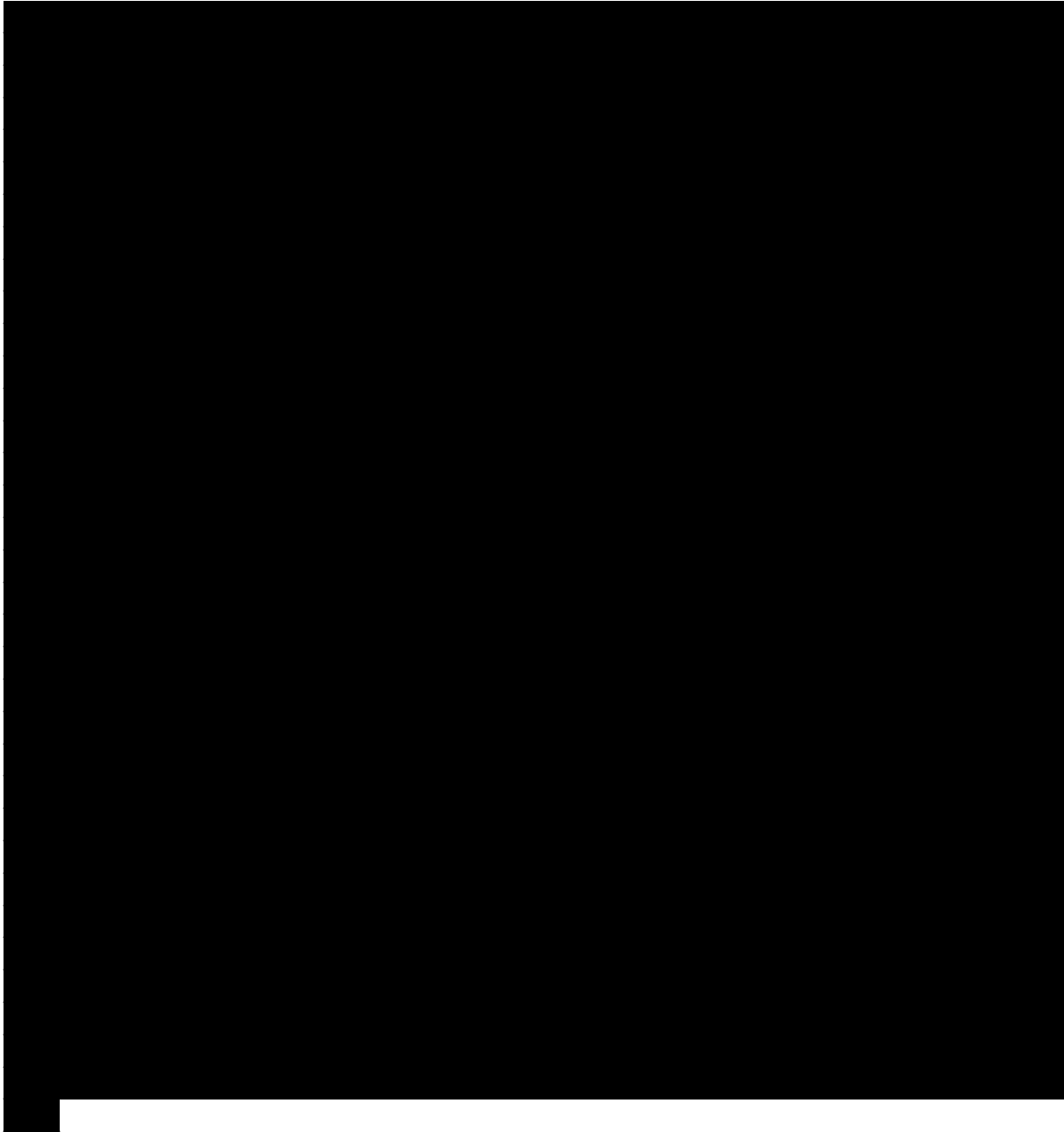




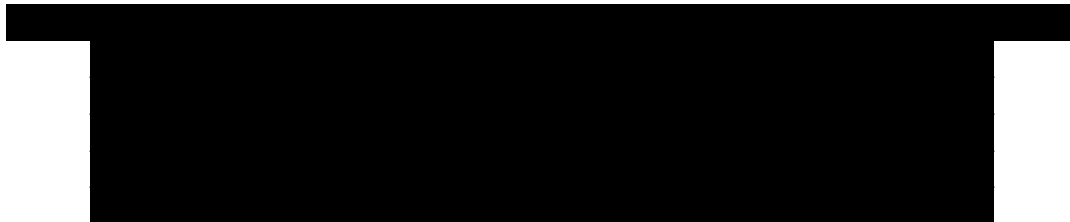
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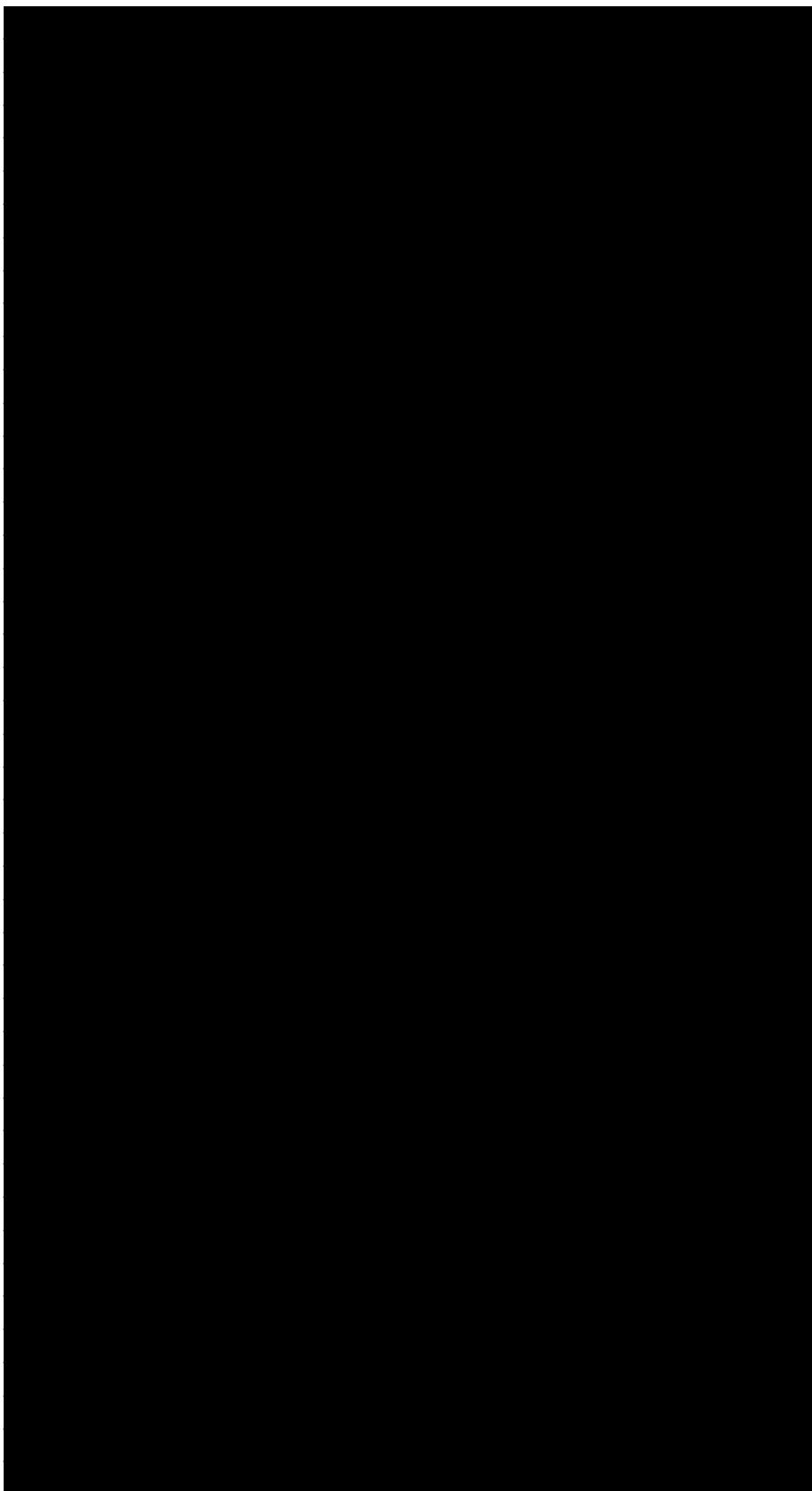




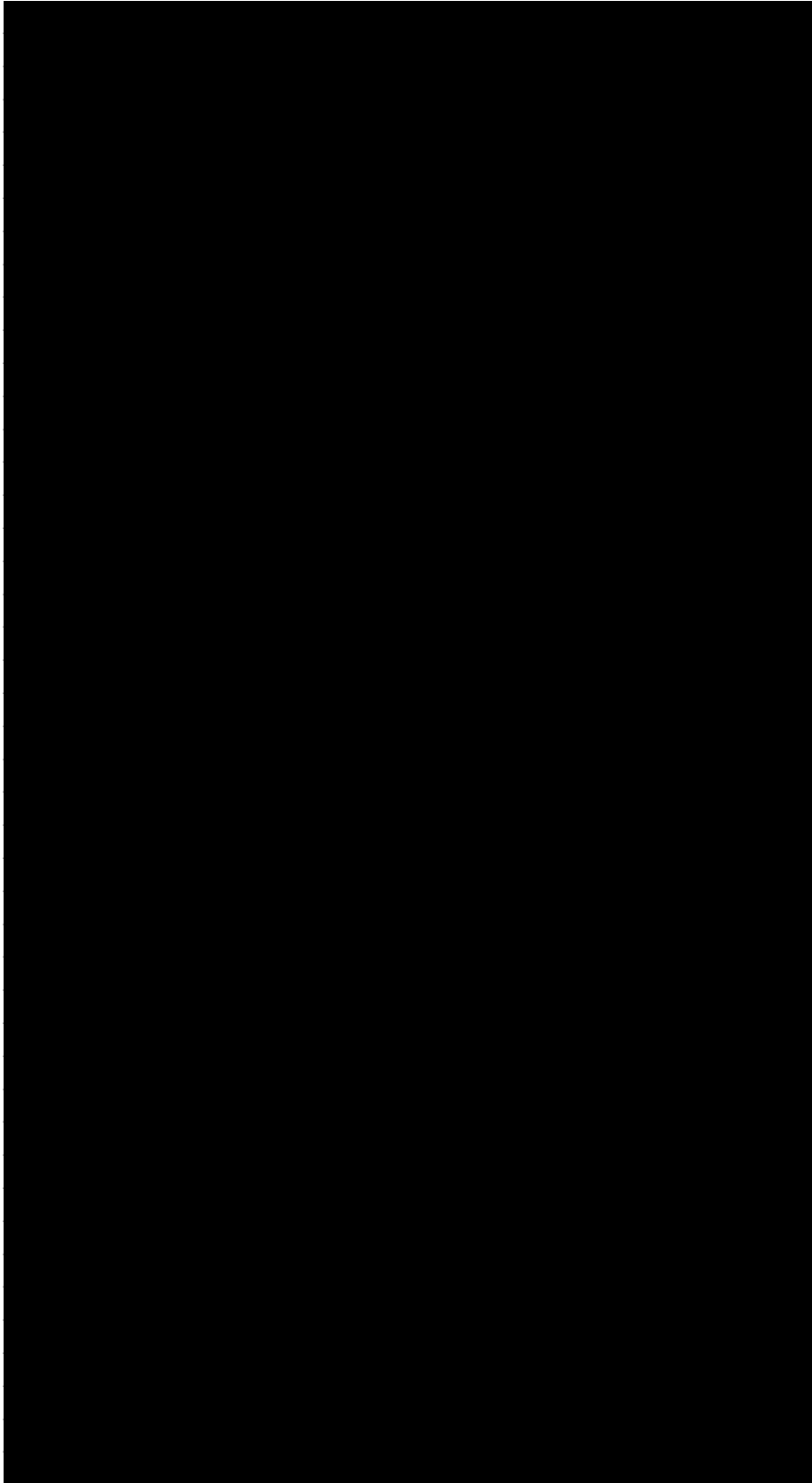


- (a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

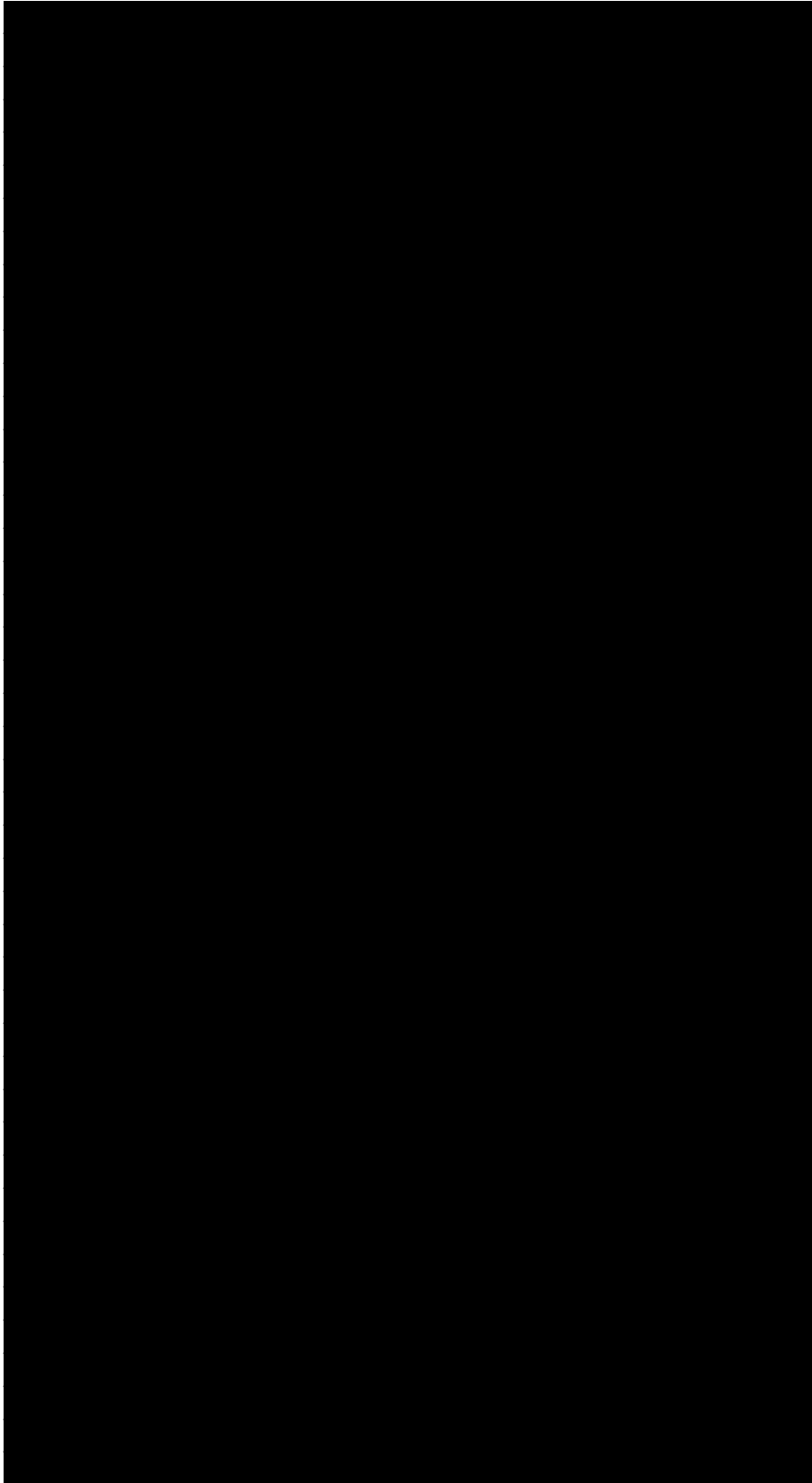




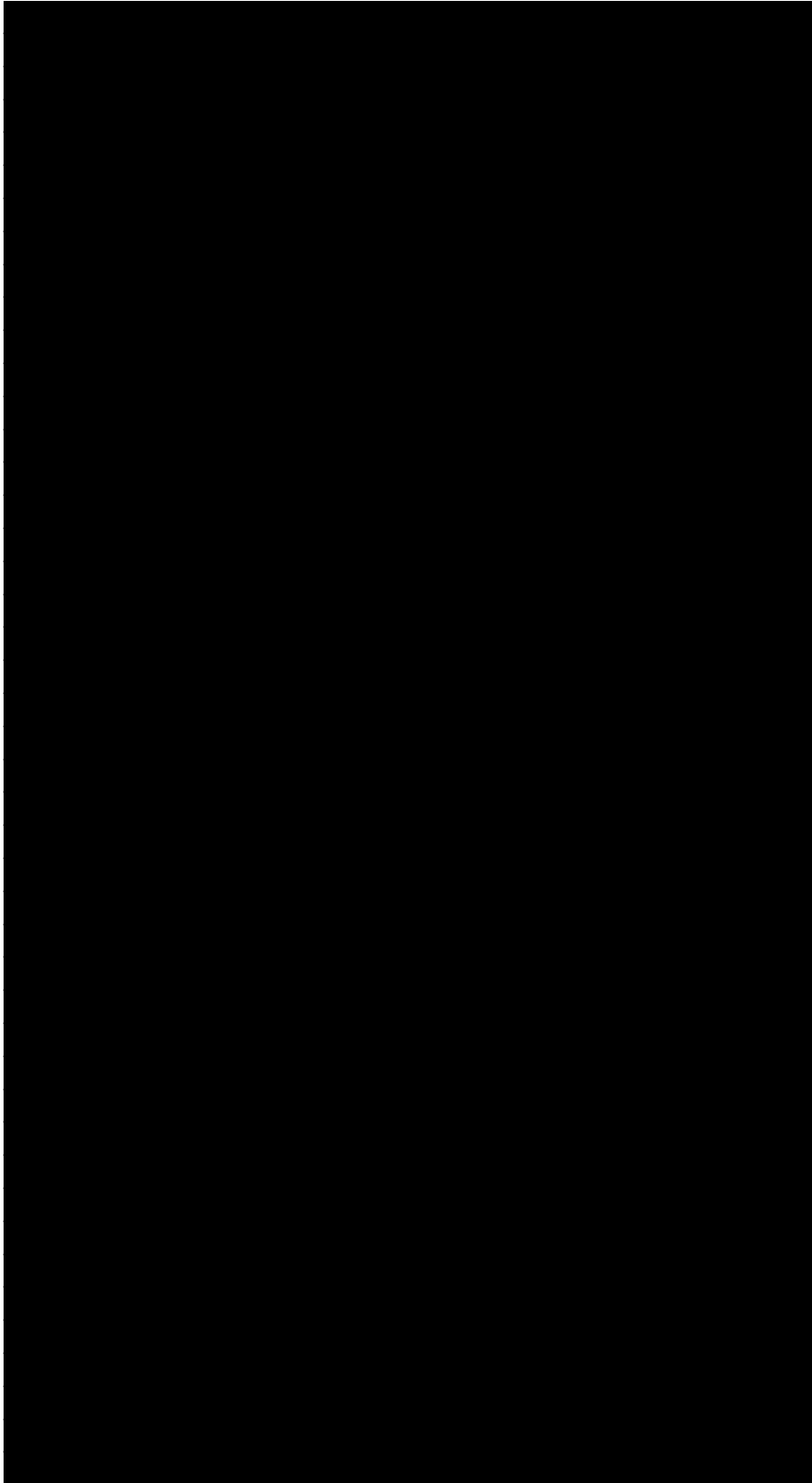
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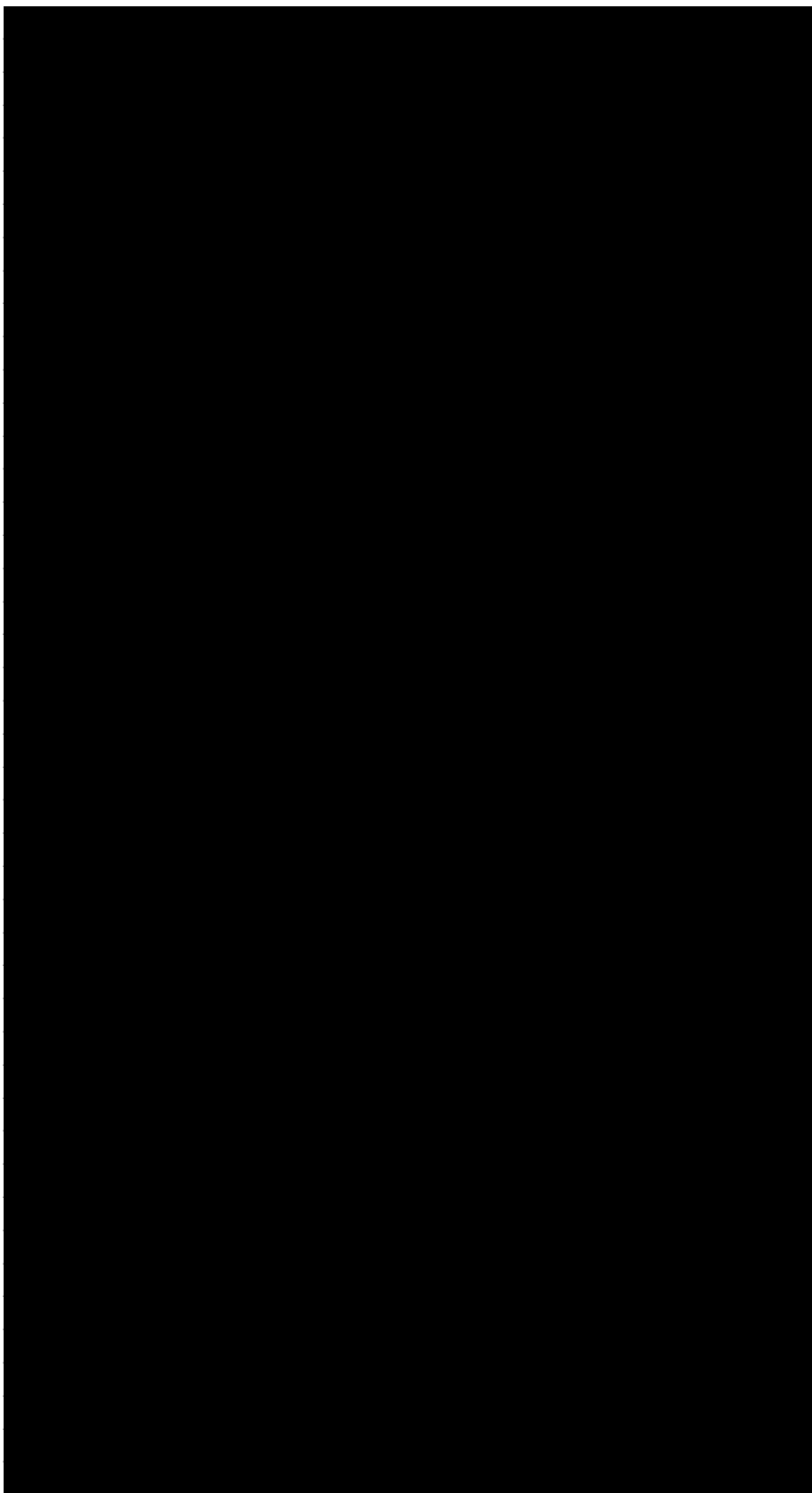


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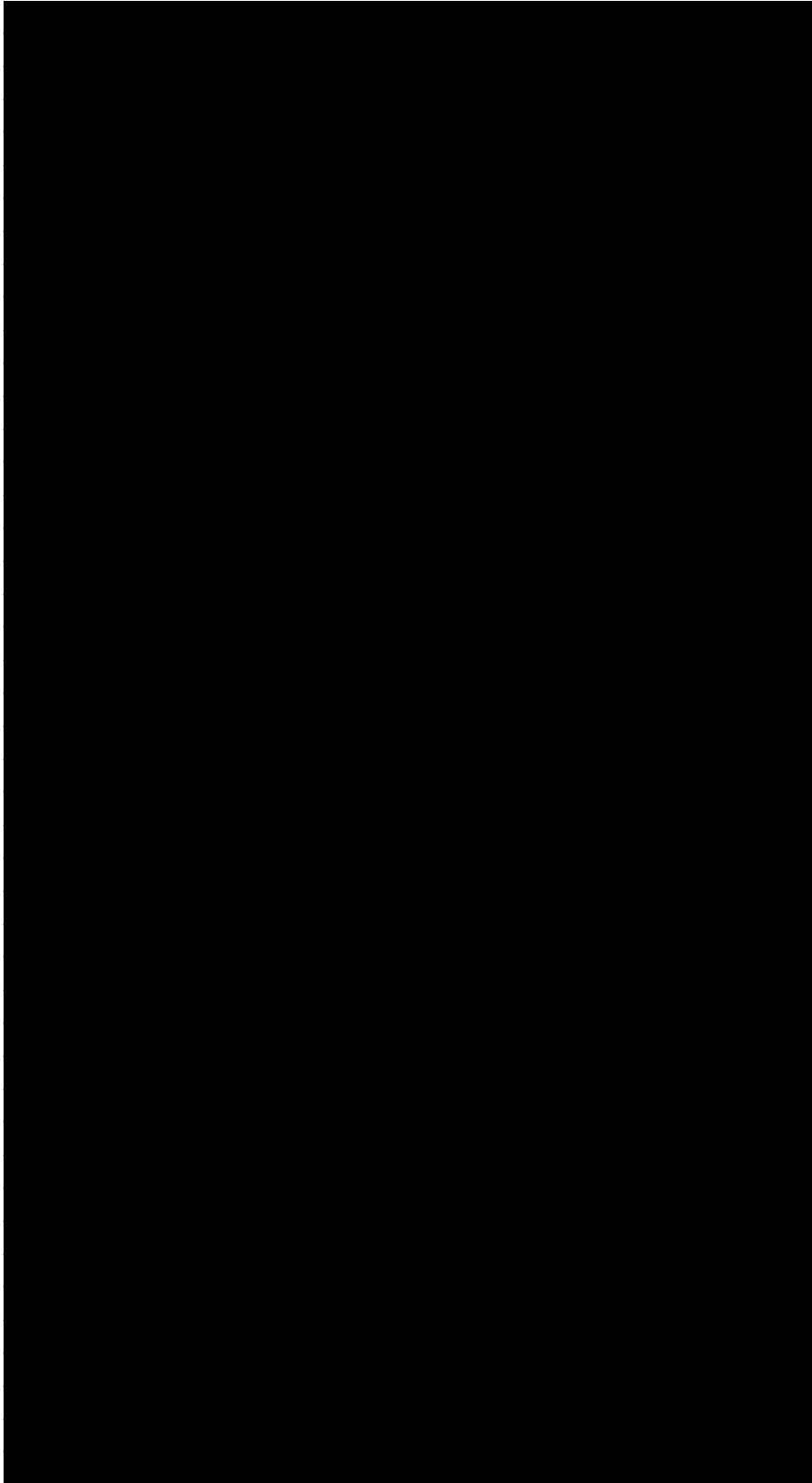


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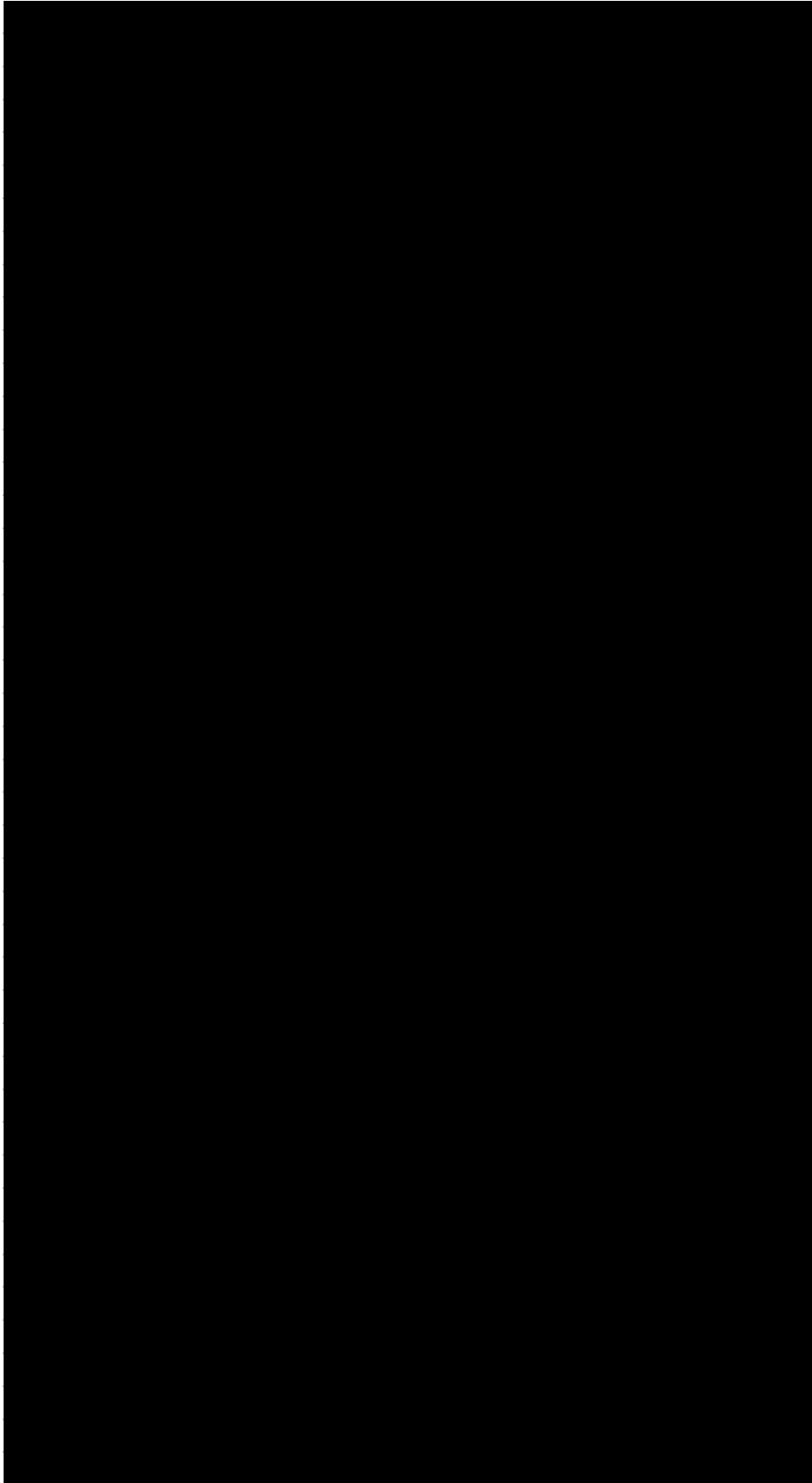




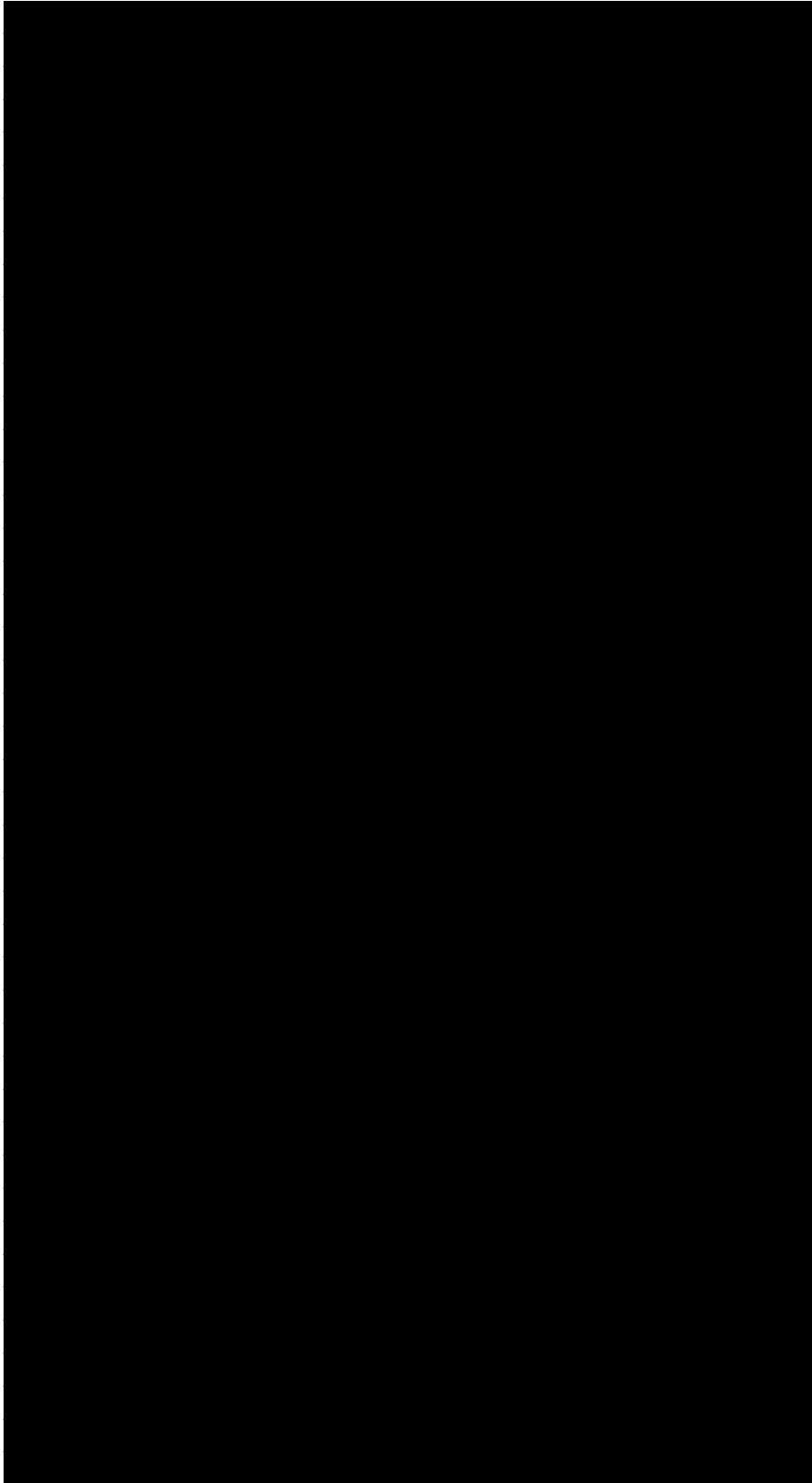
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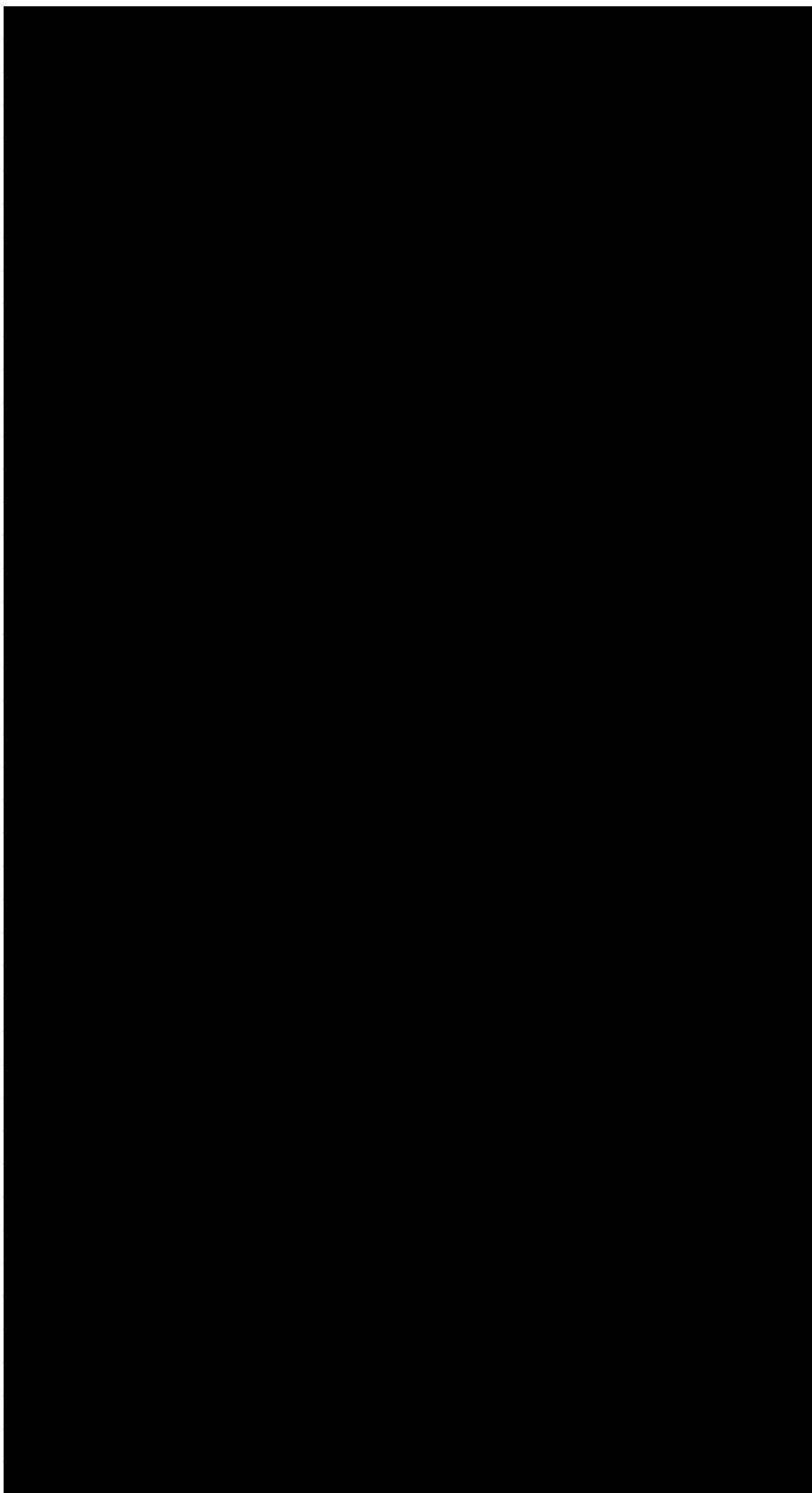


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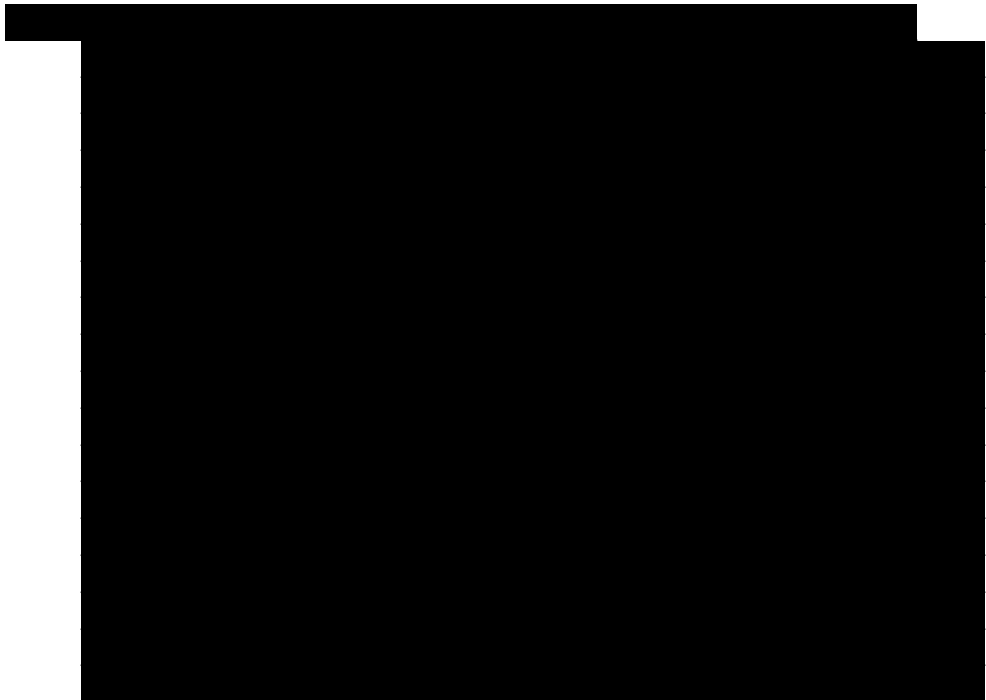
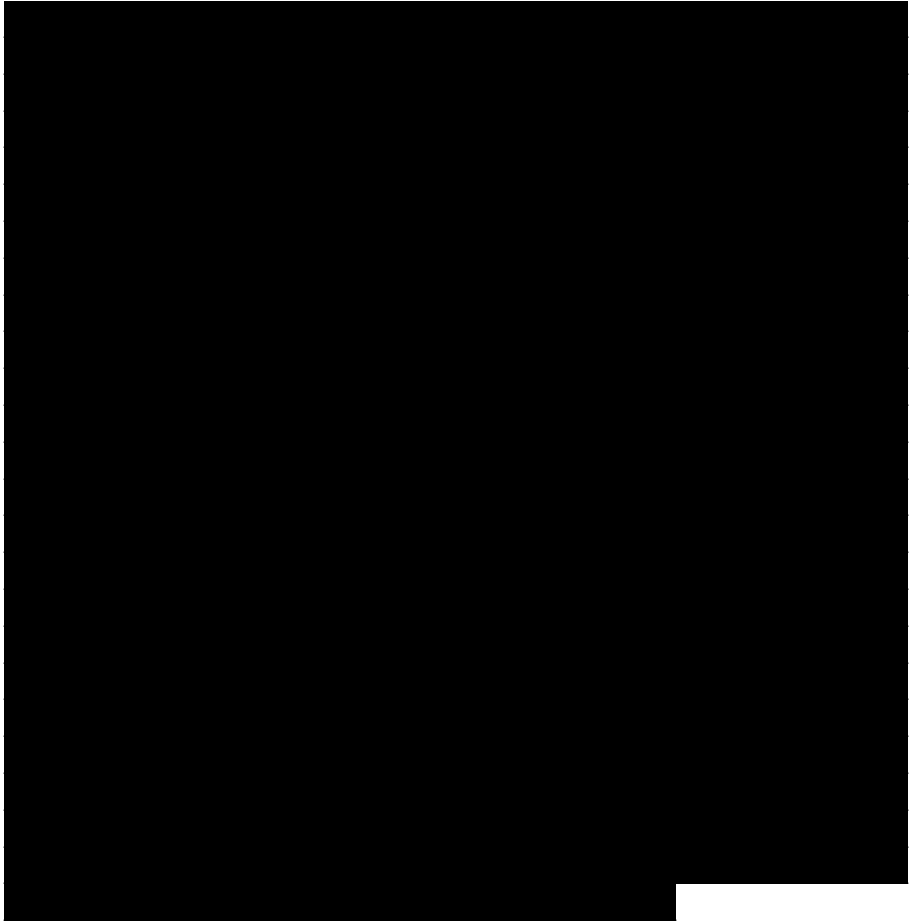


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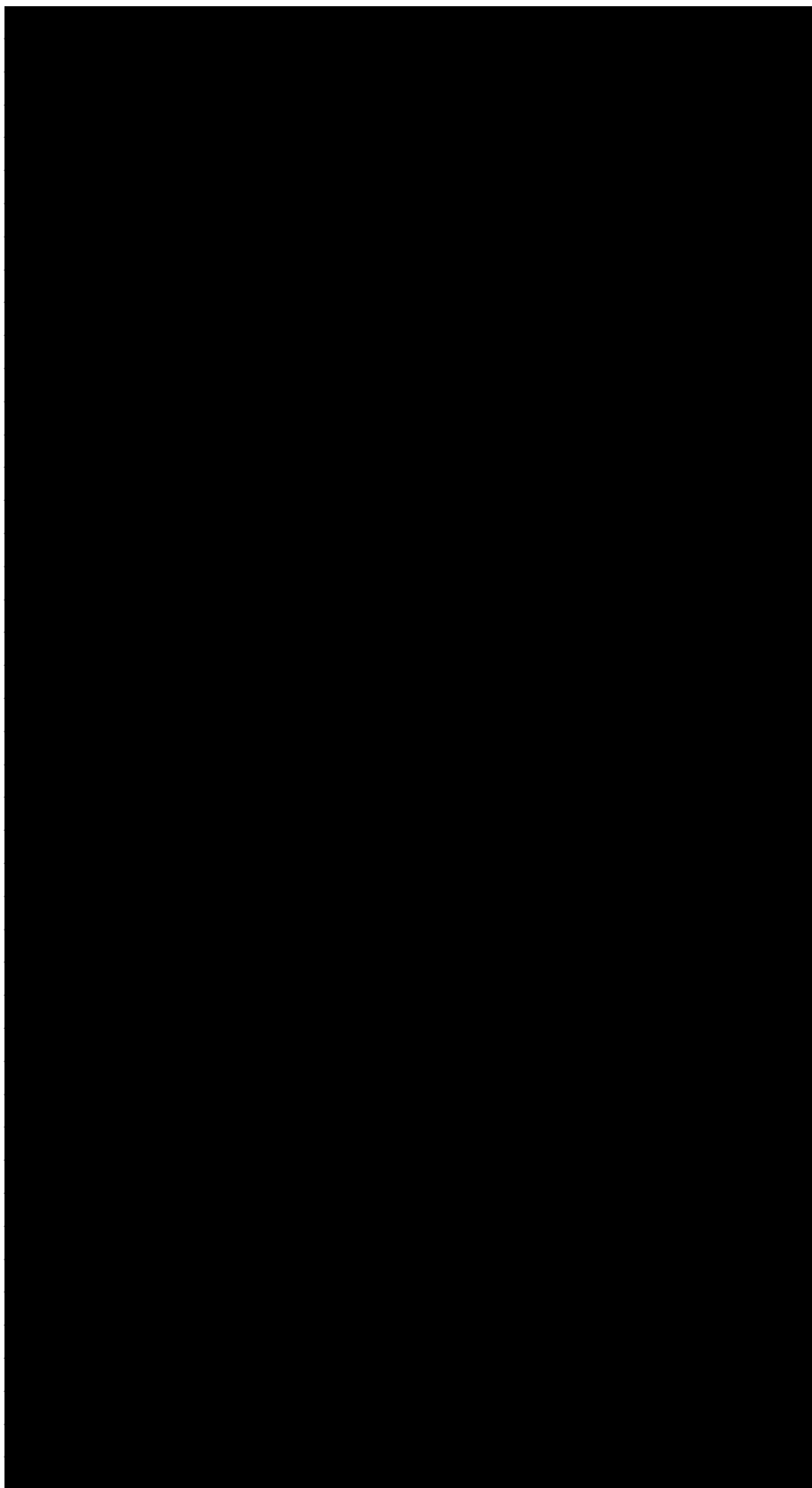




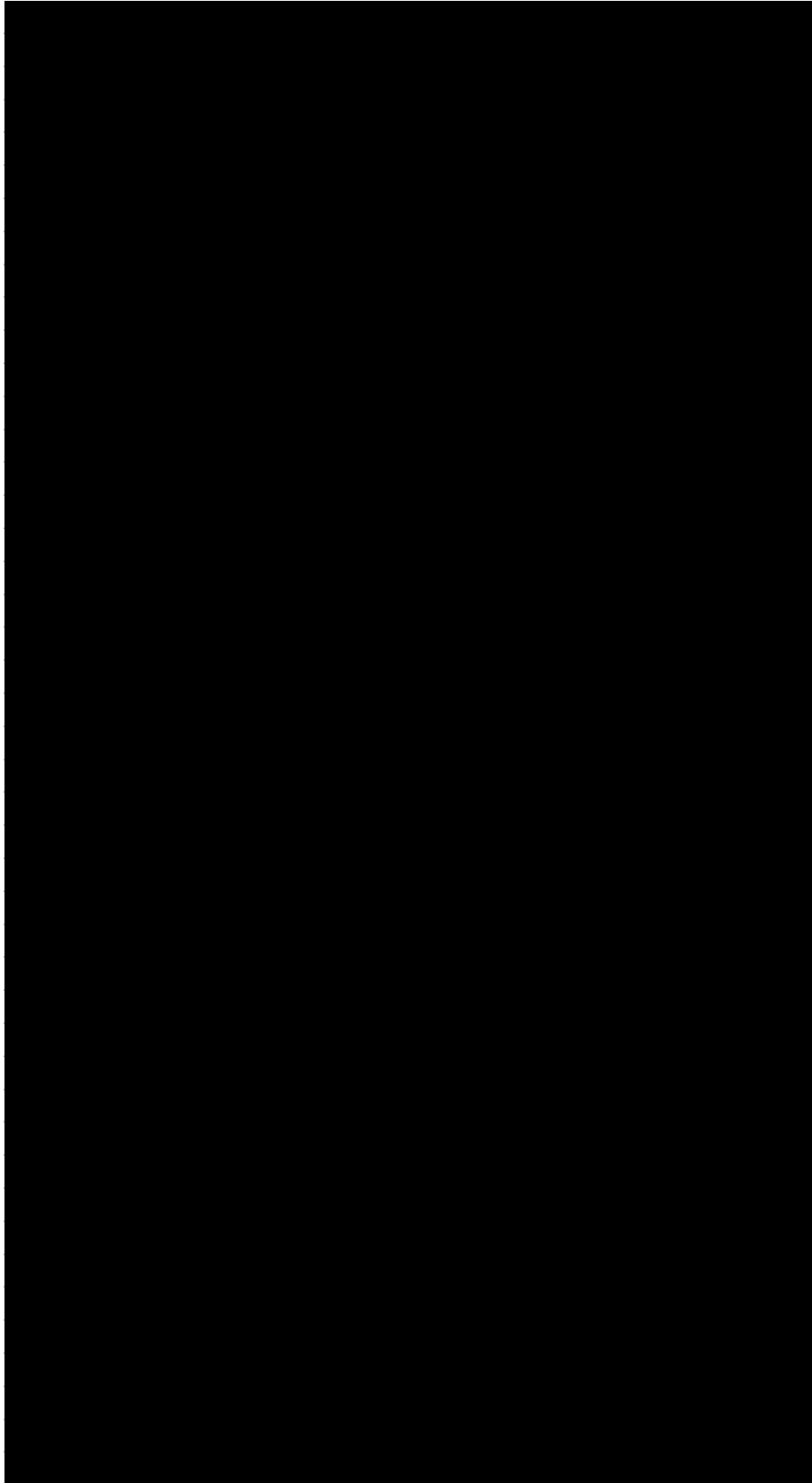
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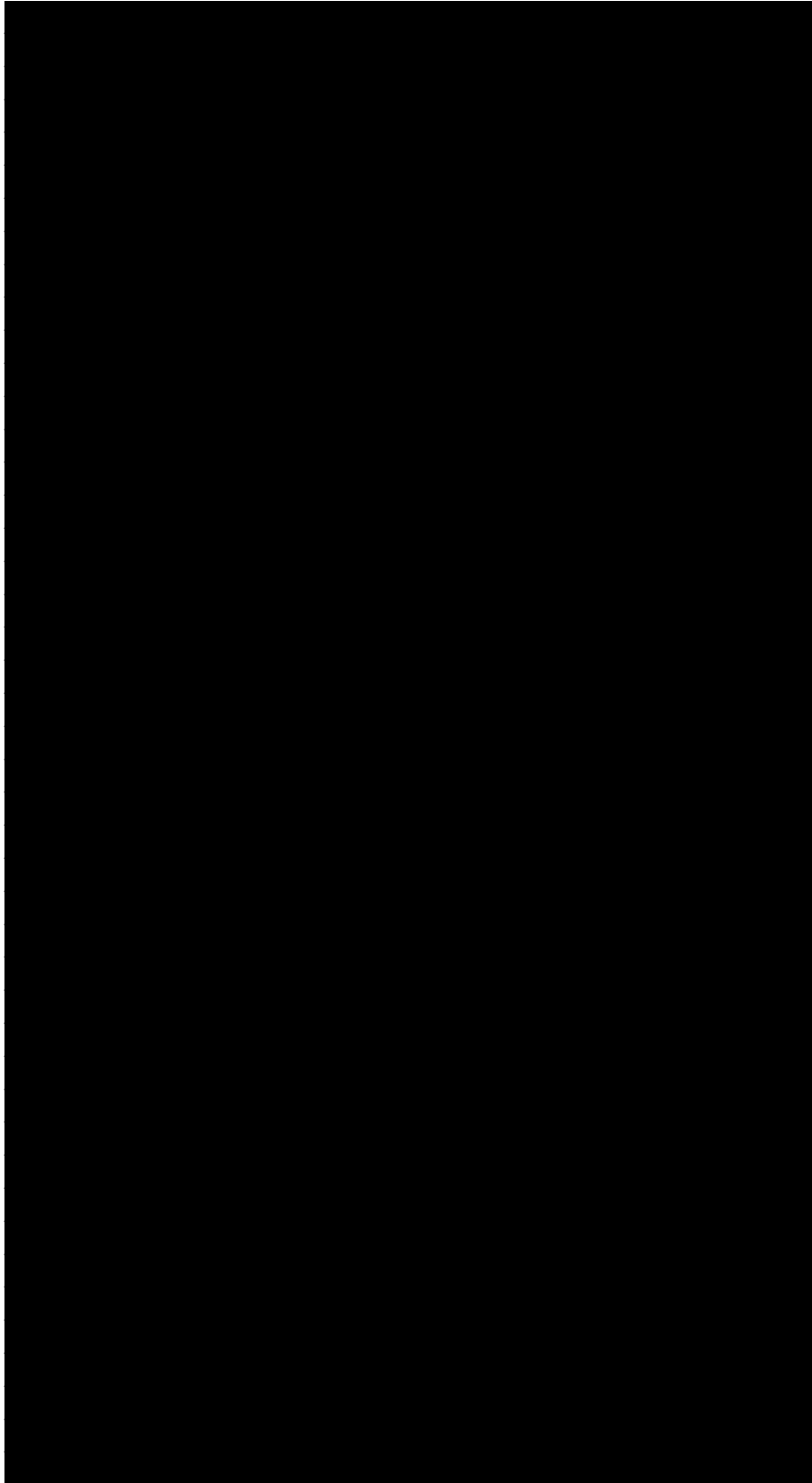
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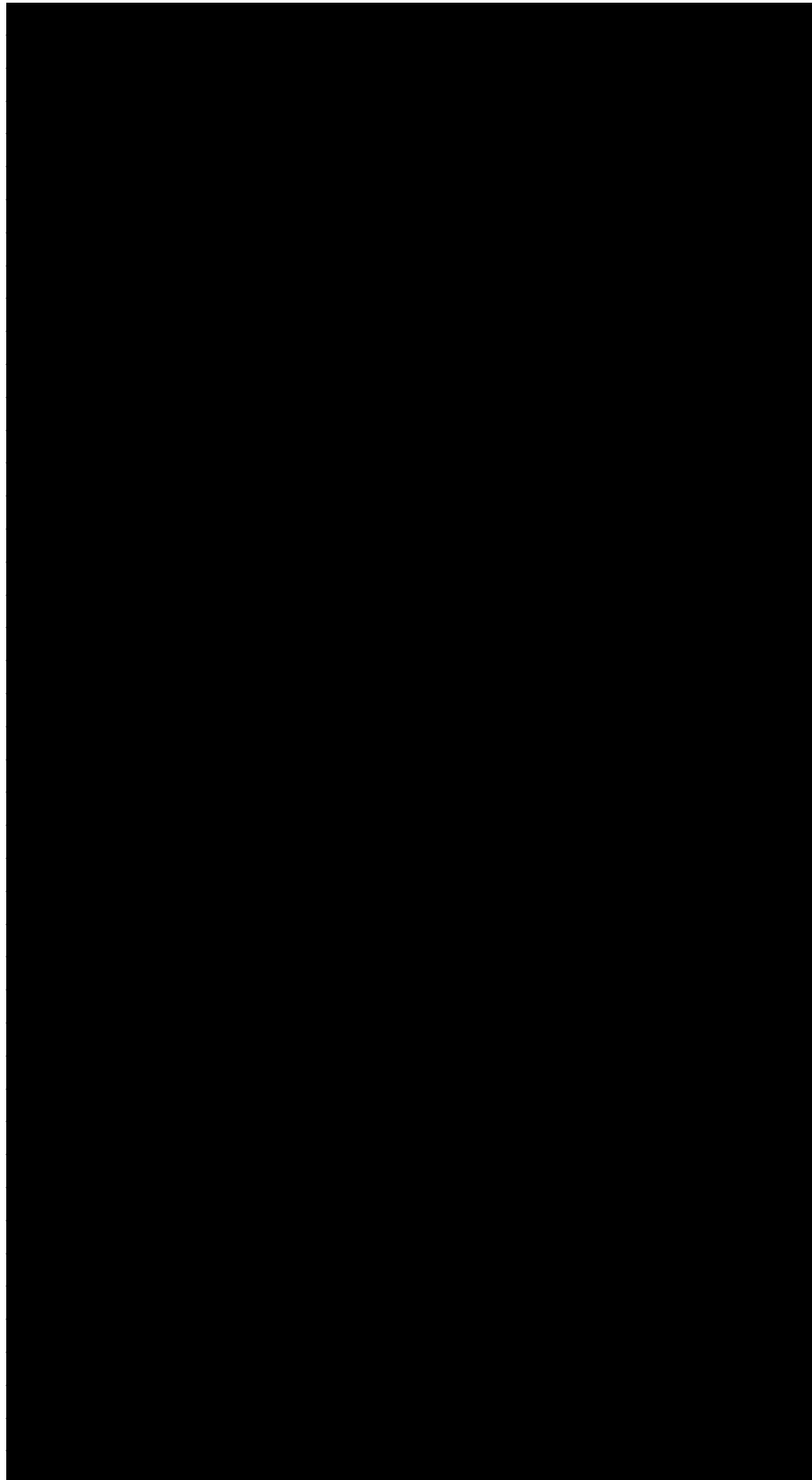
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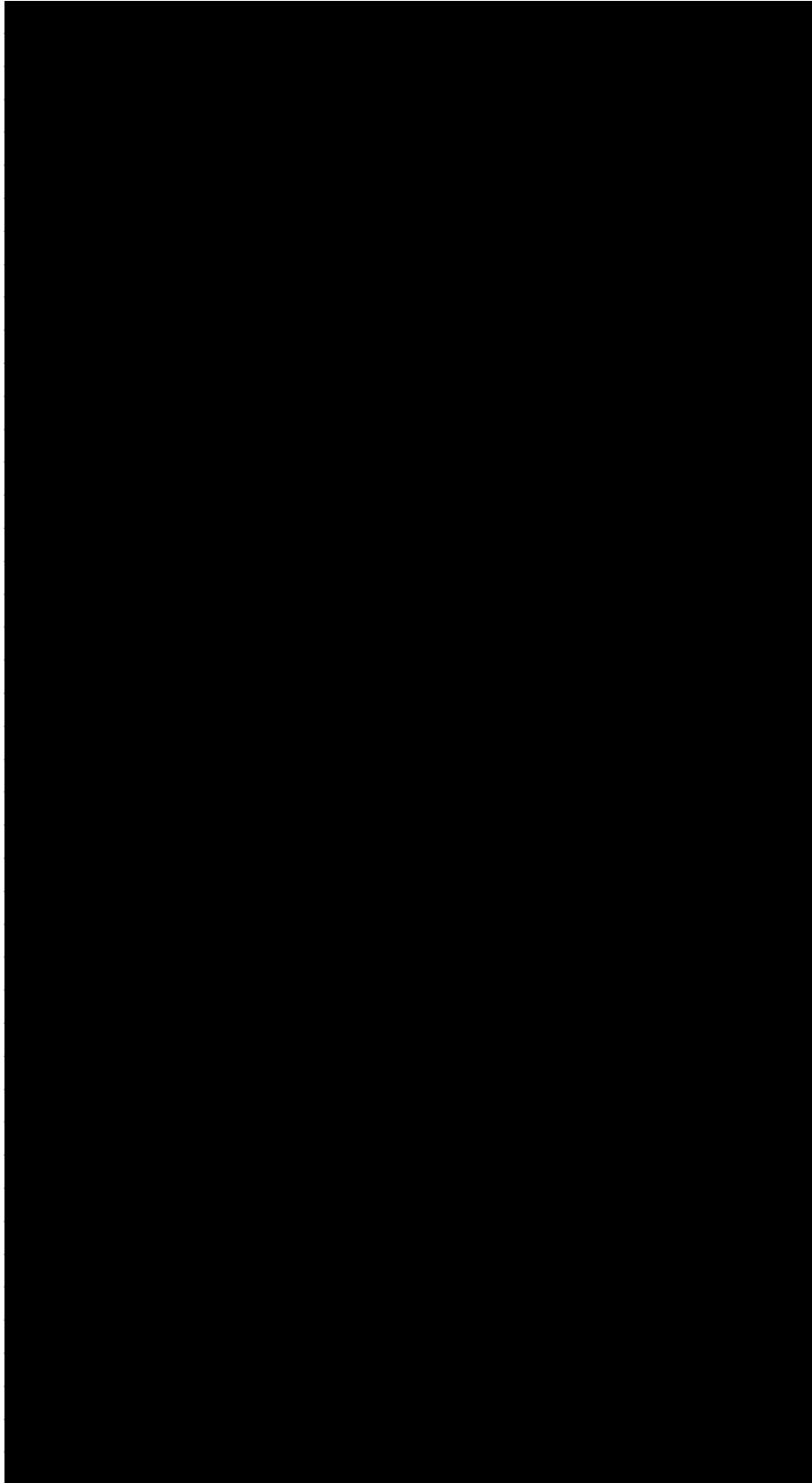
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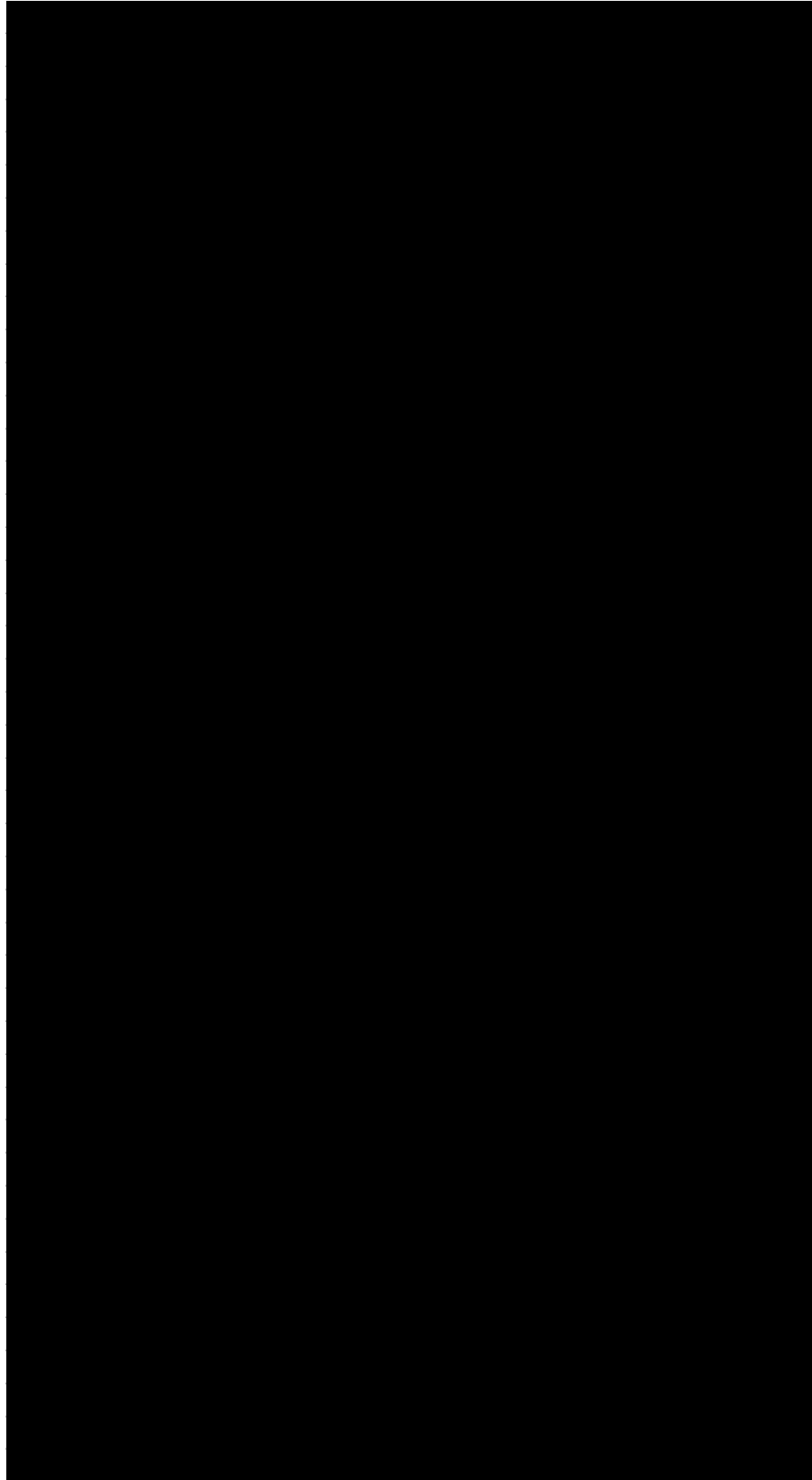
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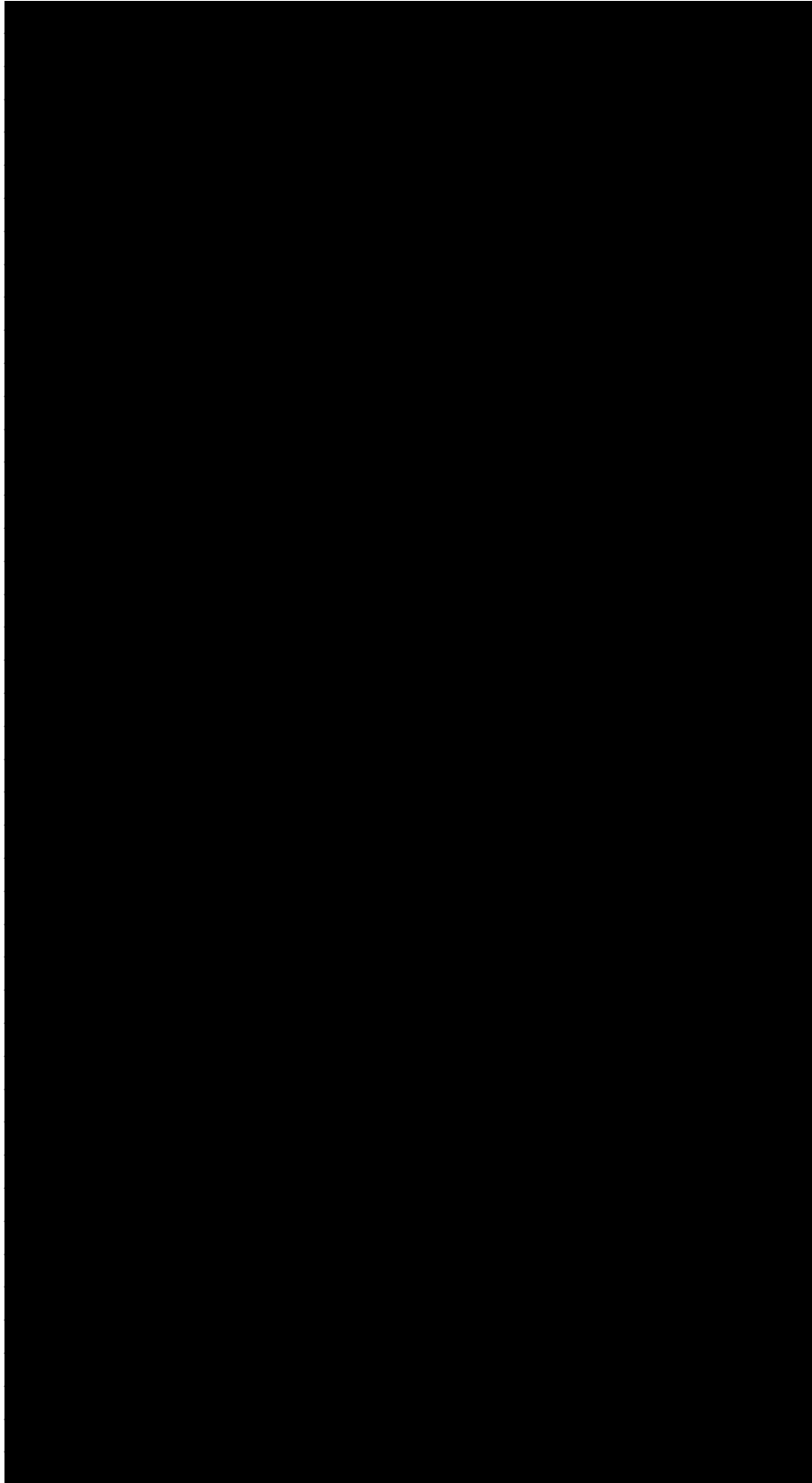
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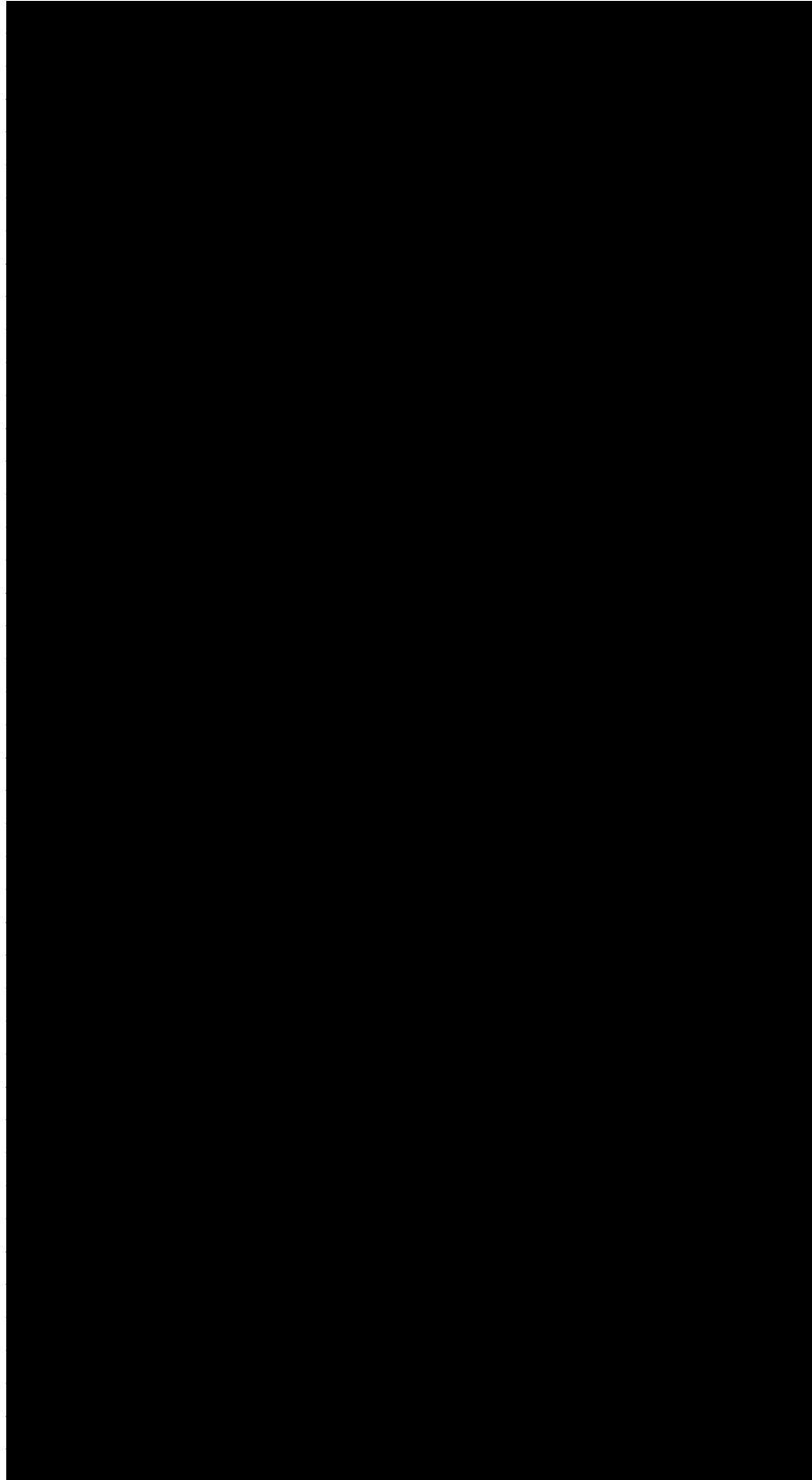
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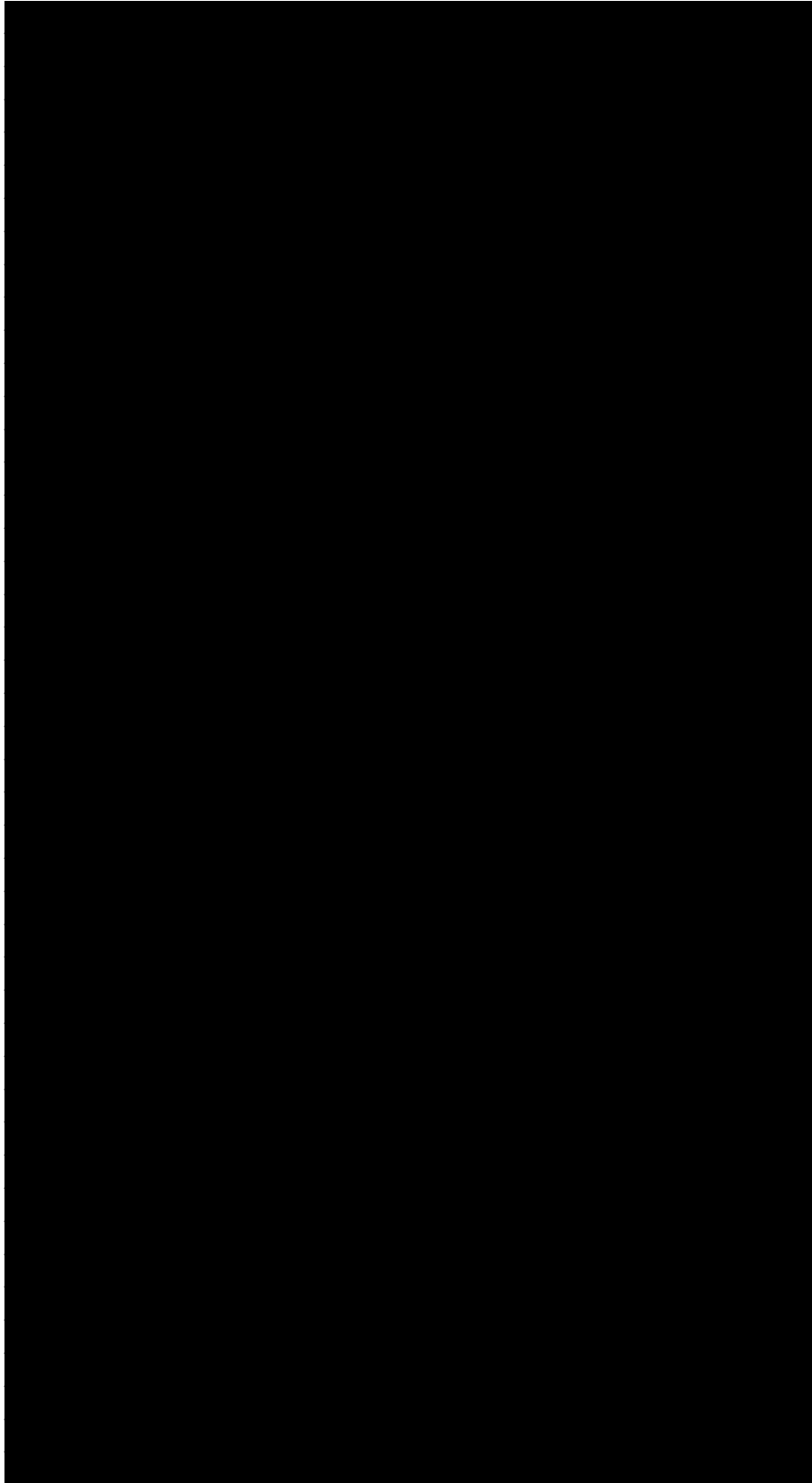
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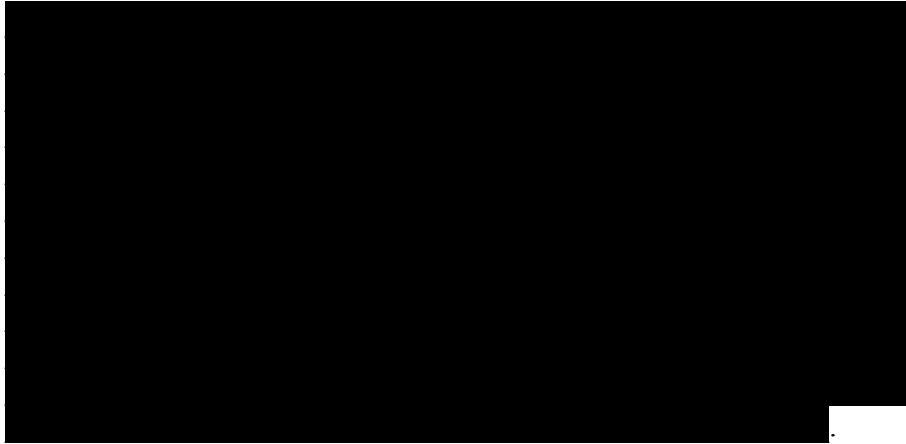
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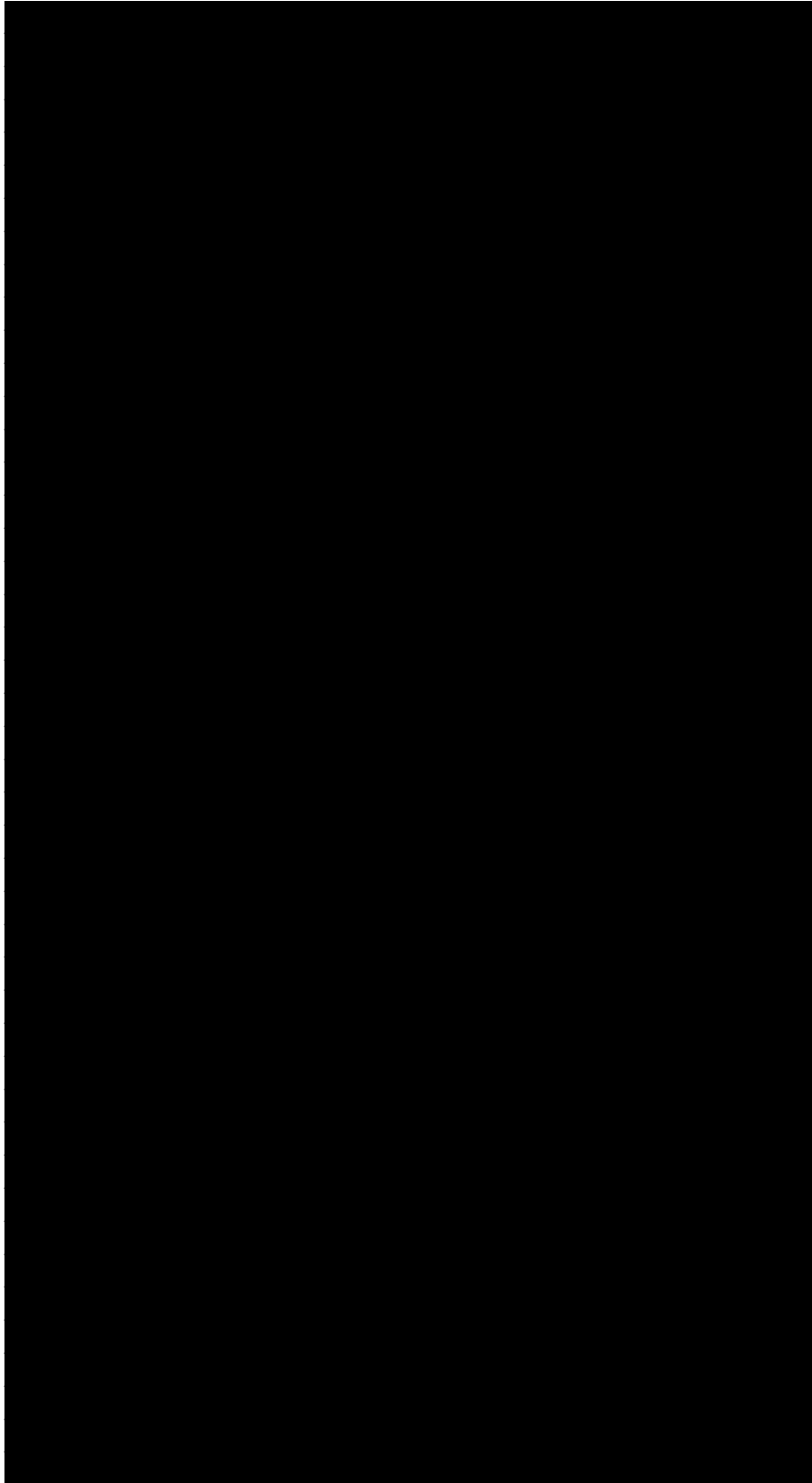
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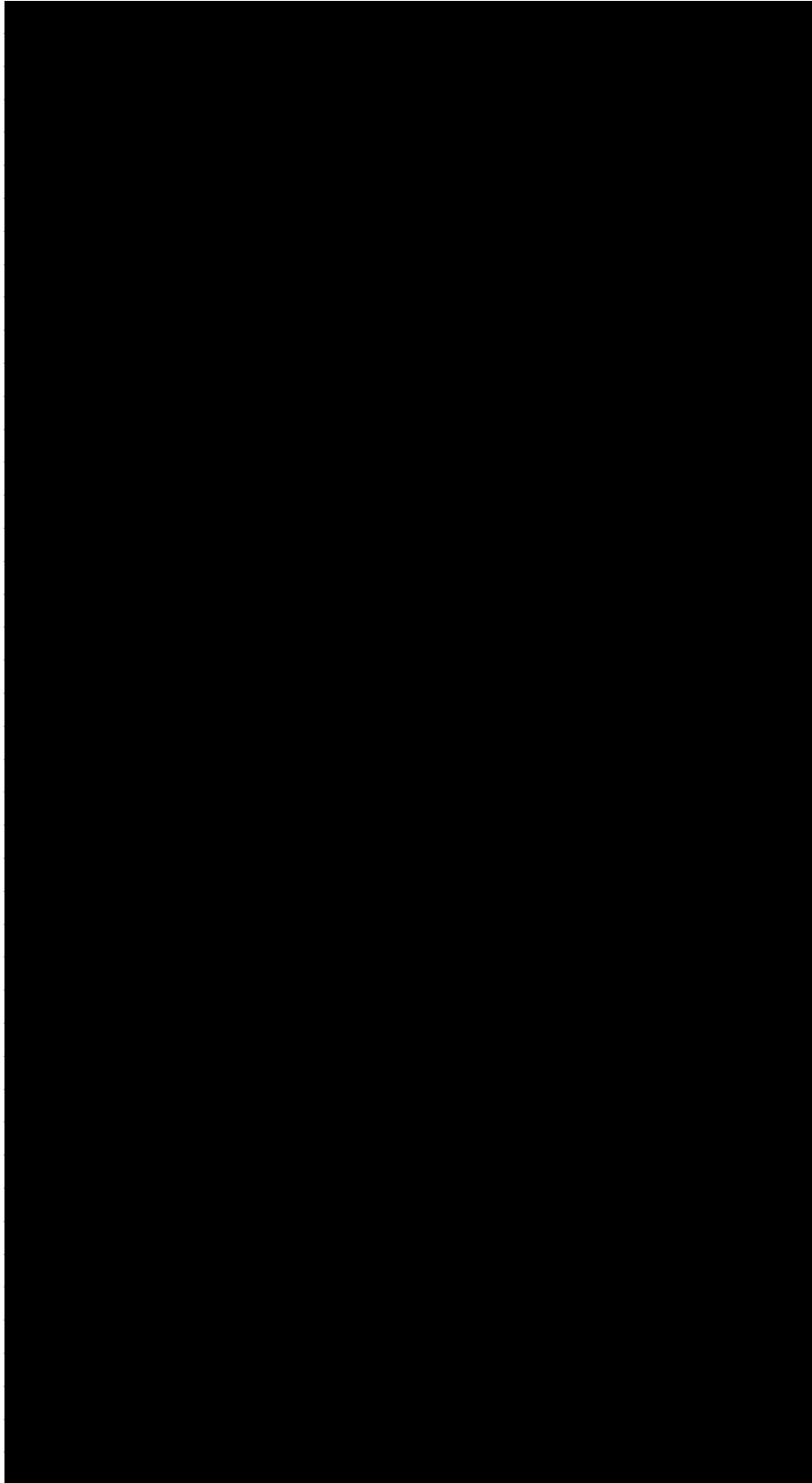
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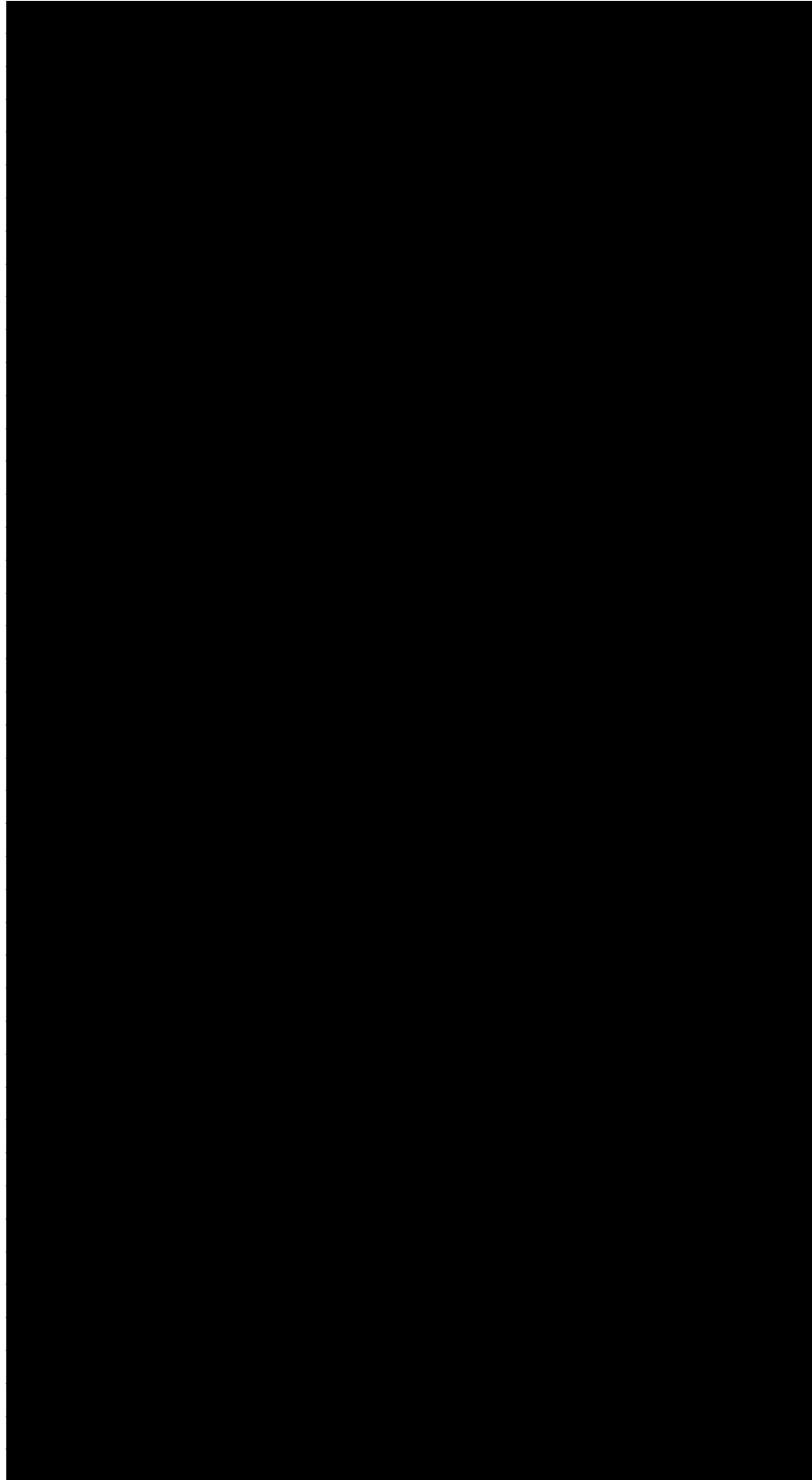
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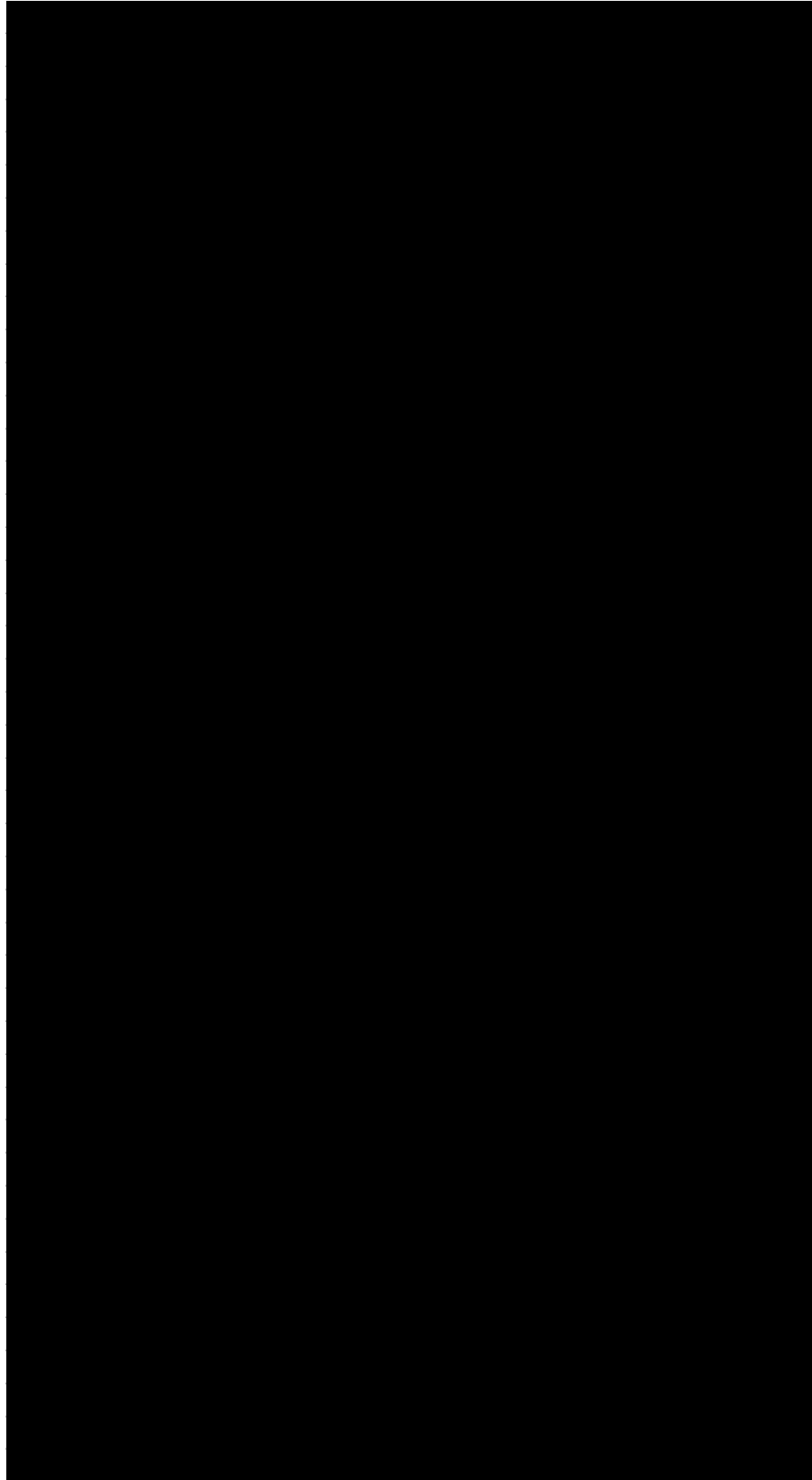
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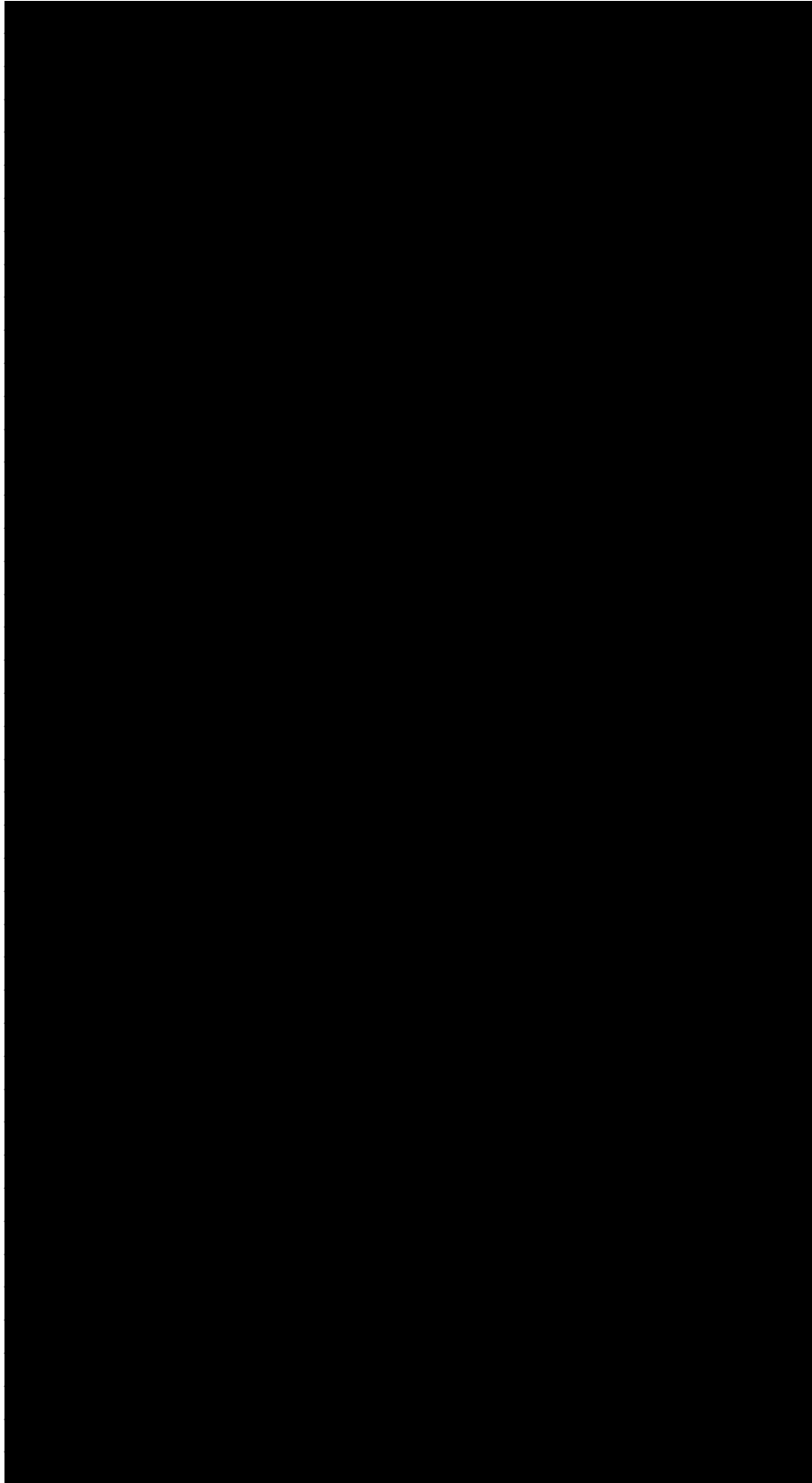


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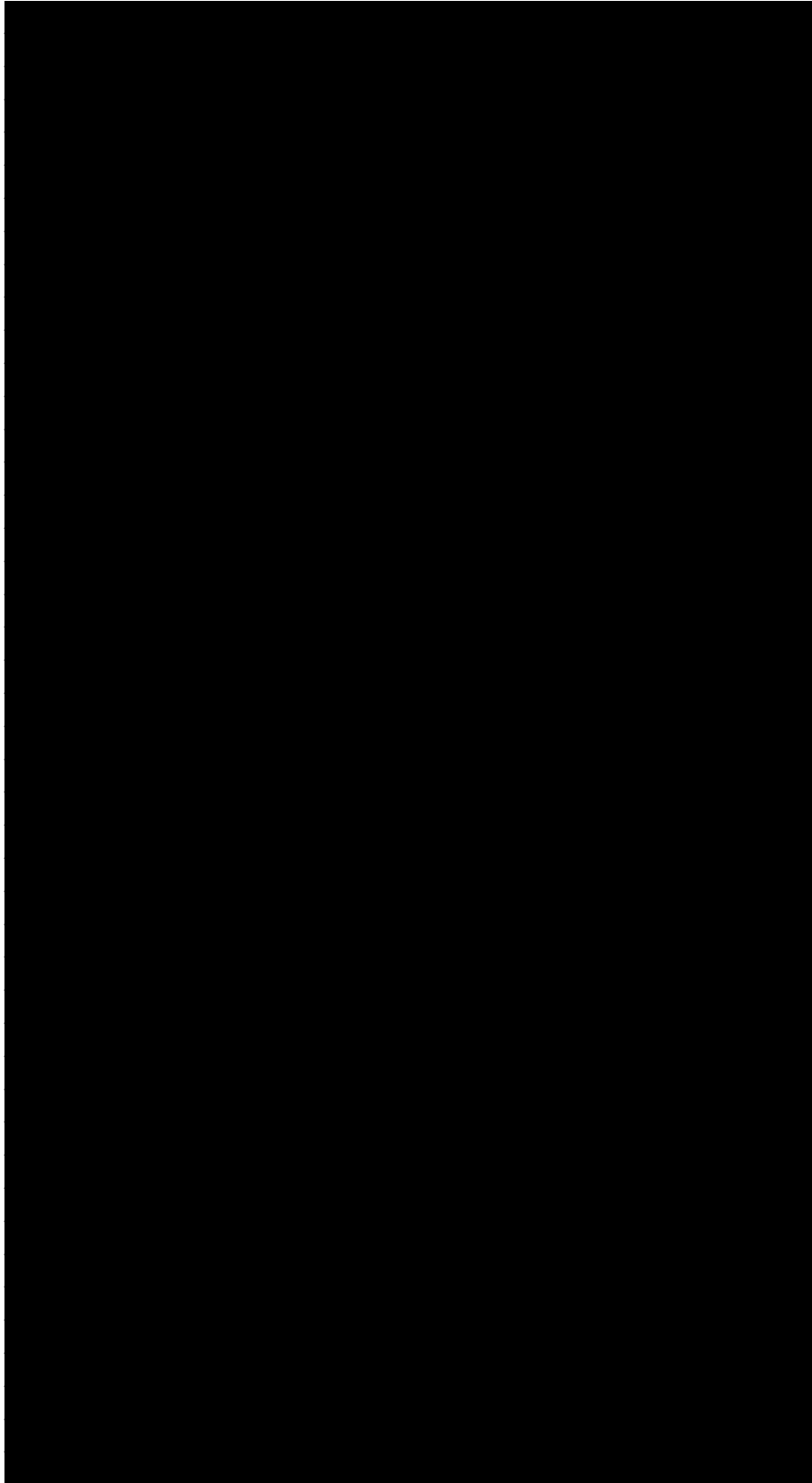


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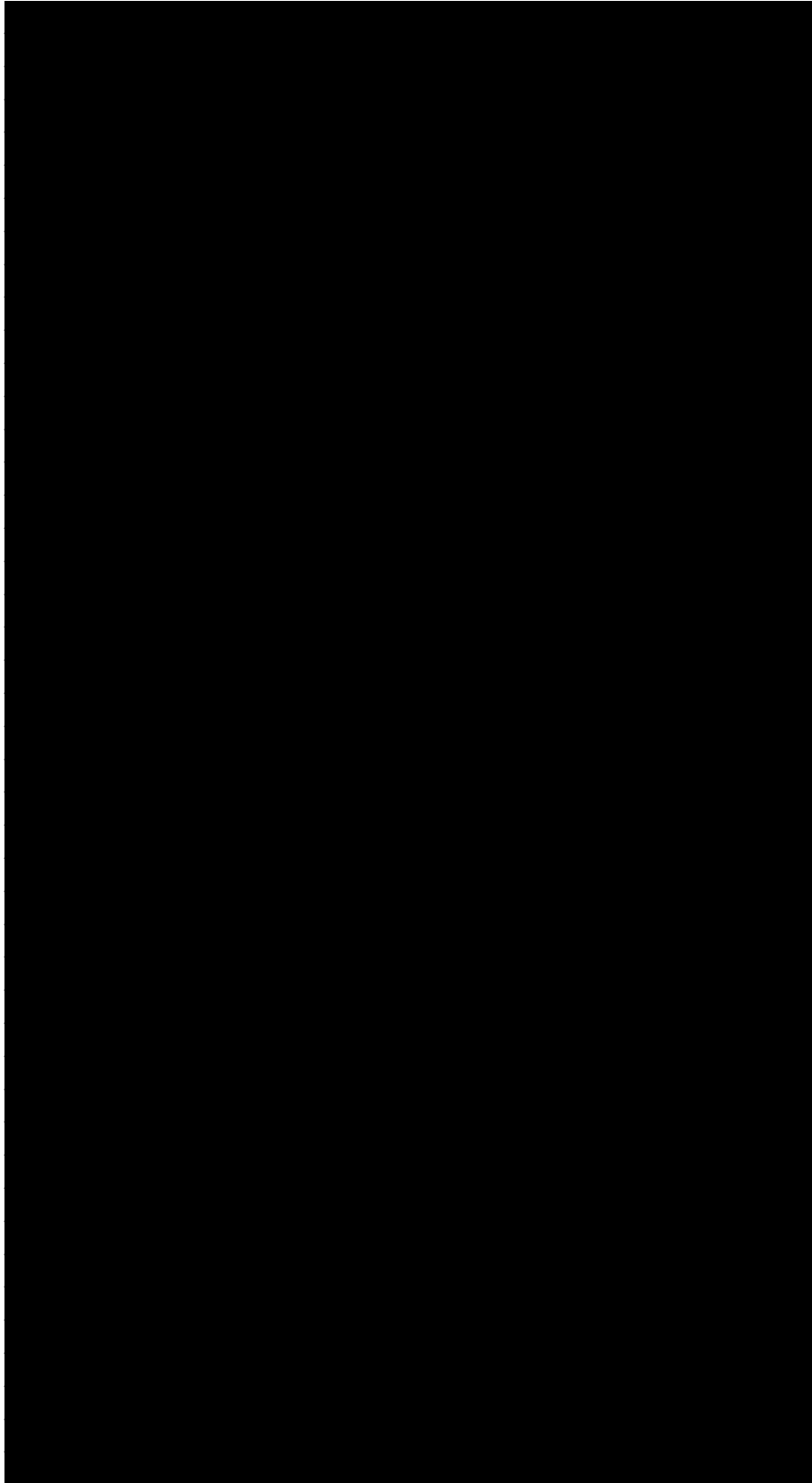




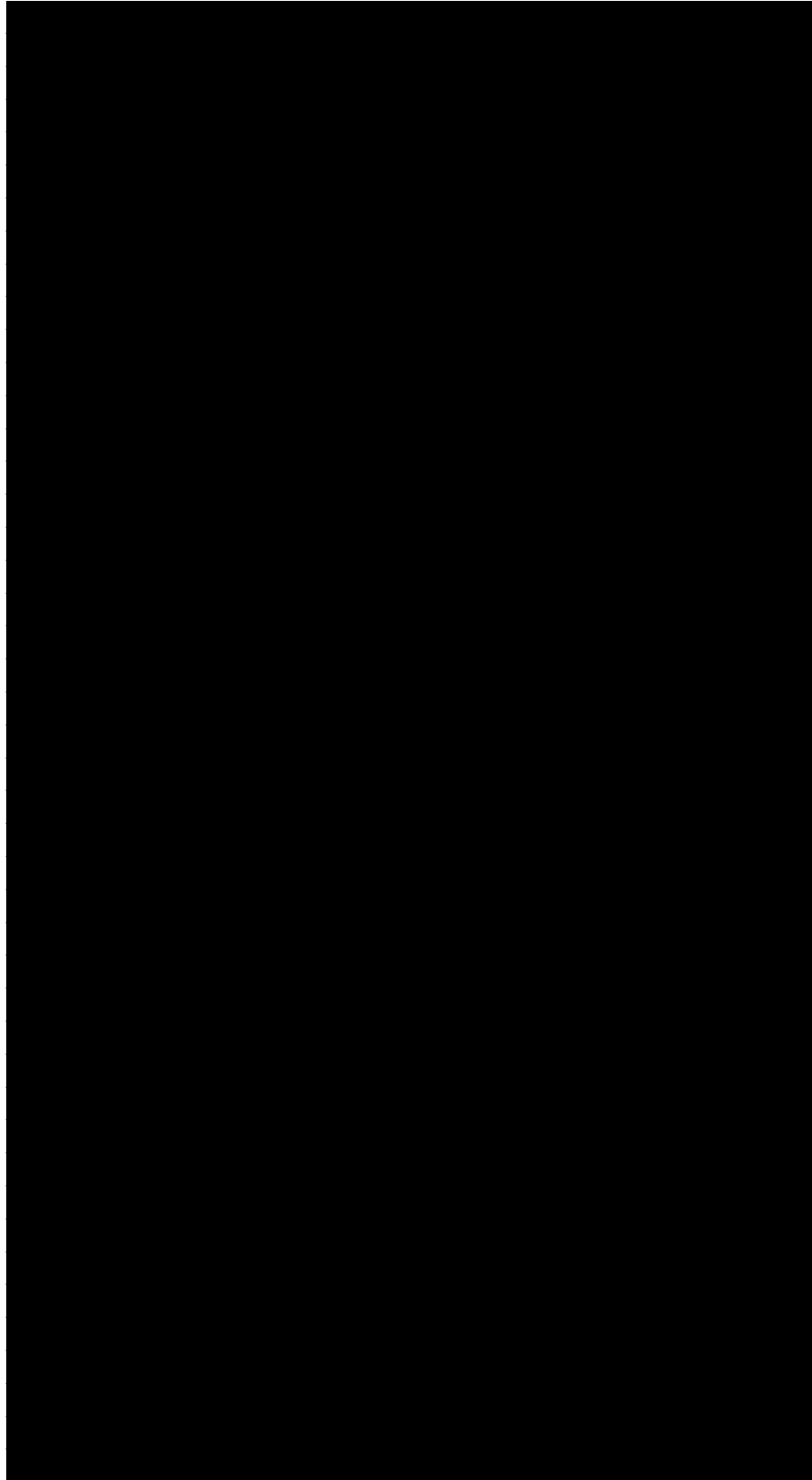
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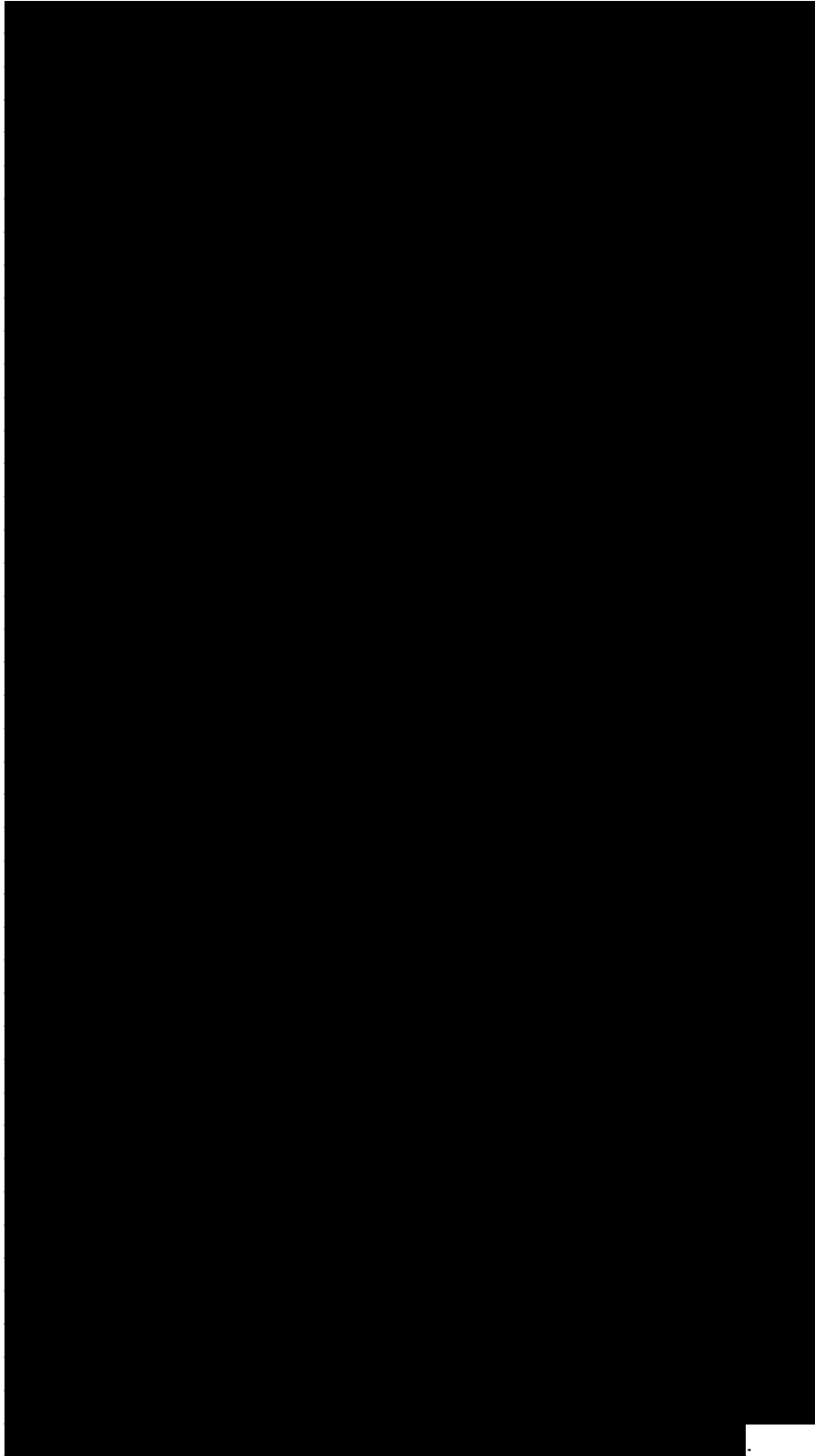
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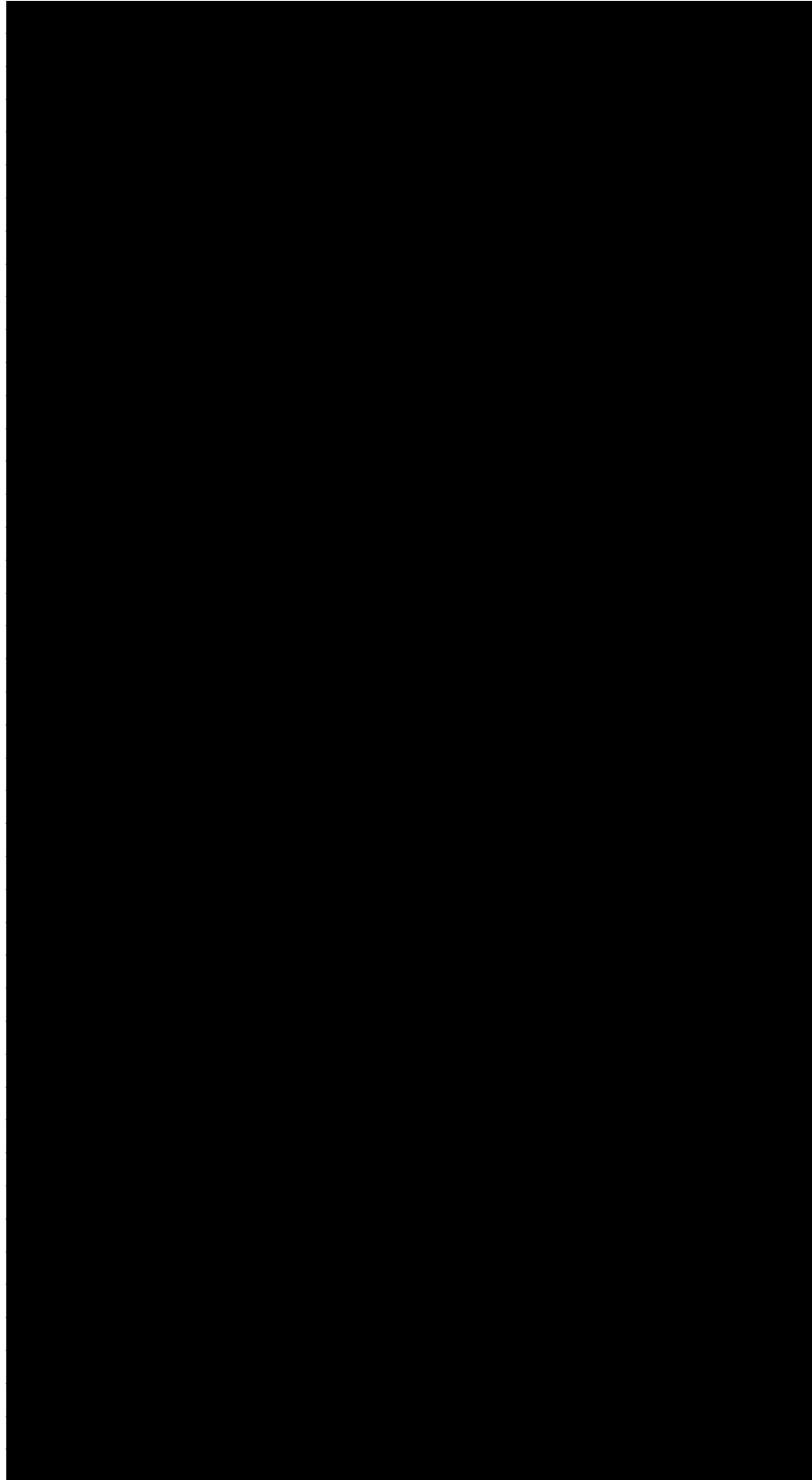
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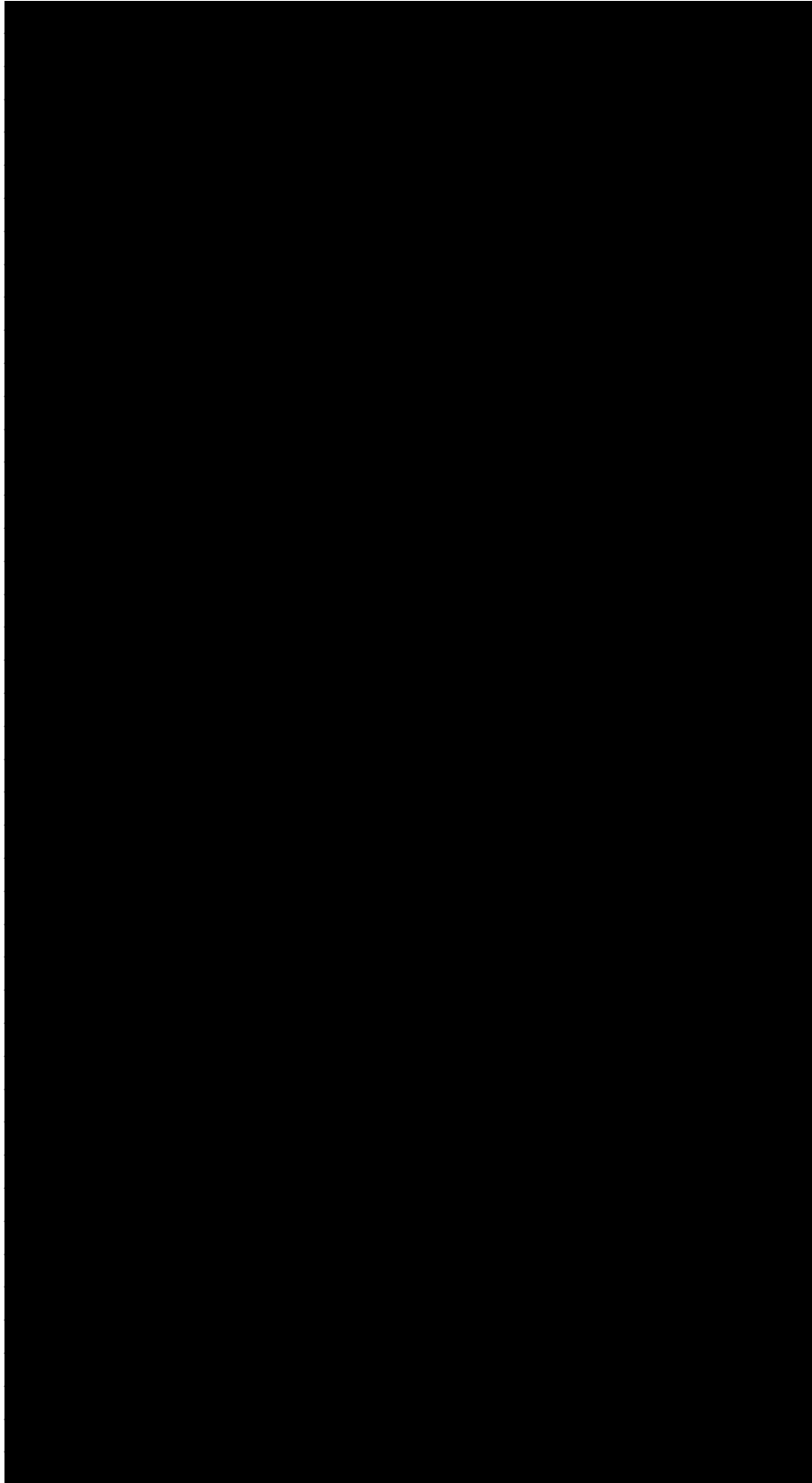
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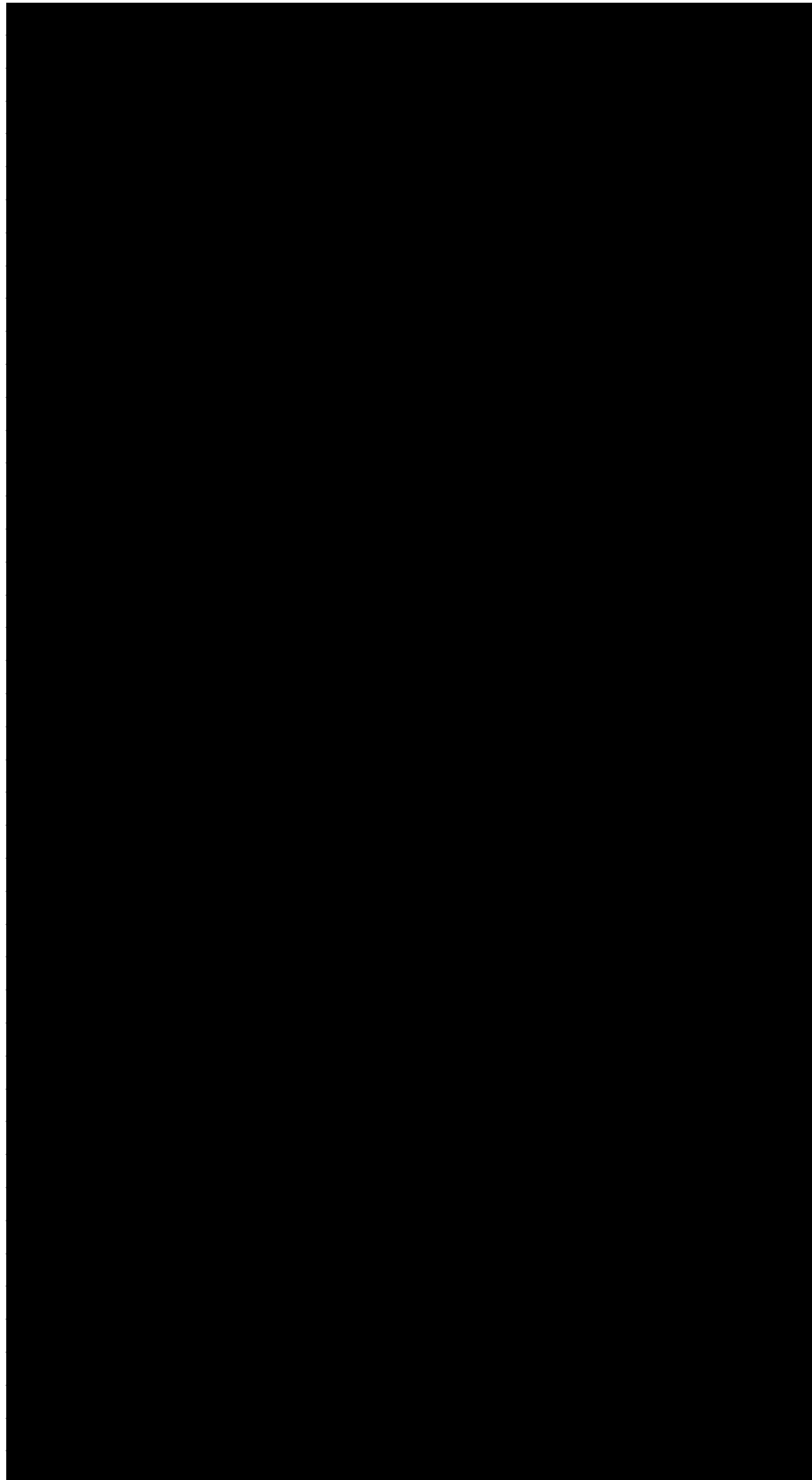
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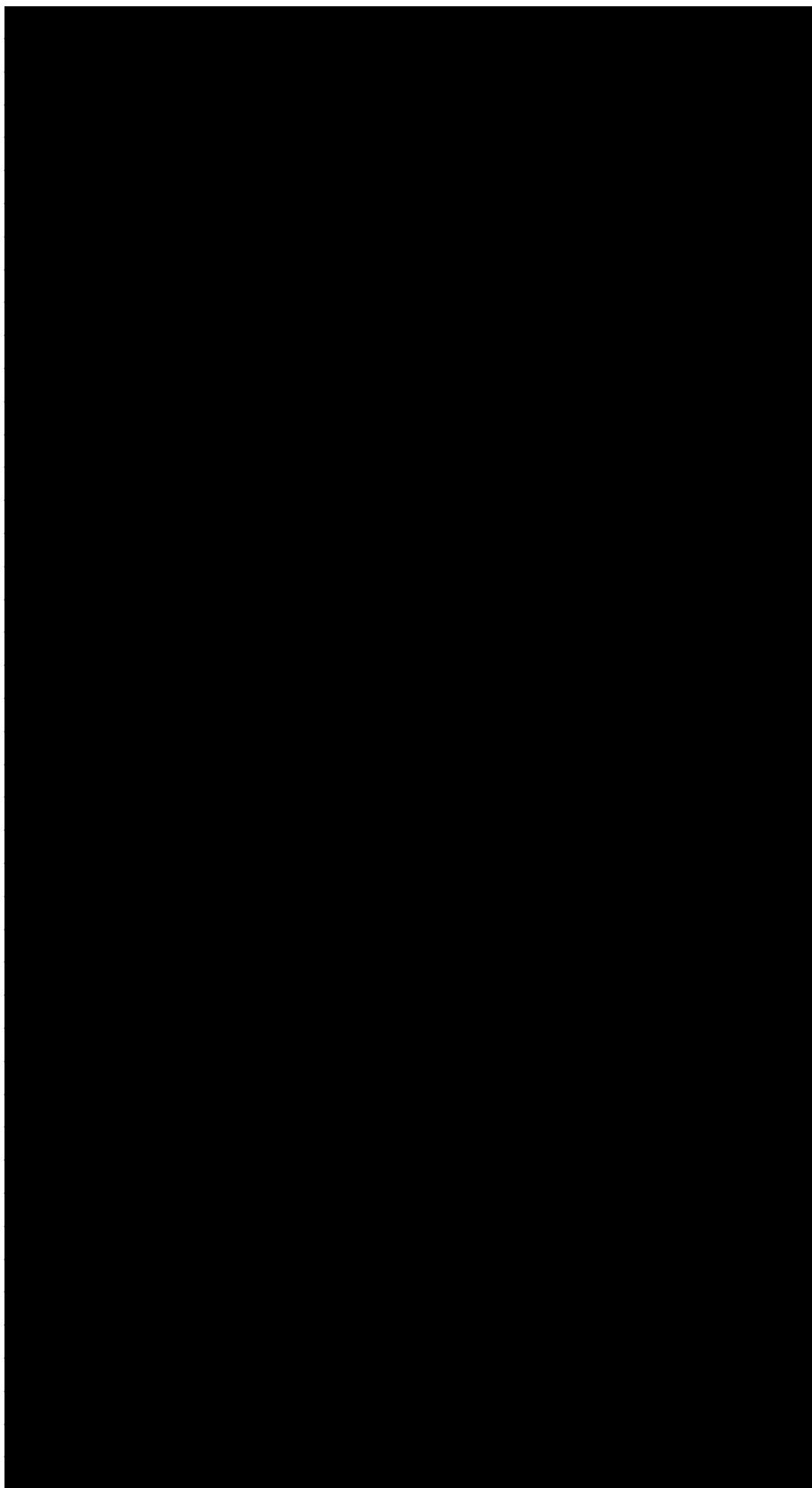
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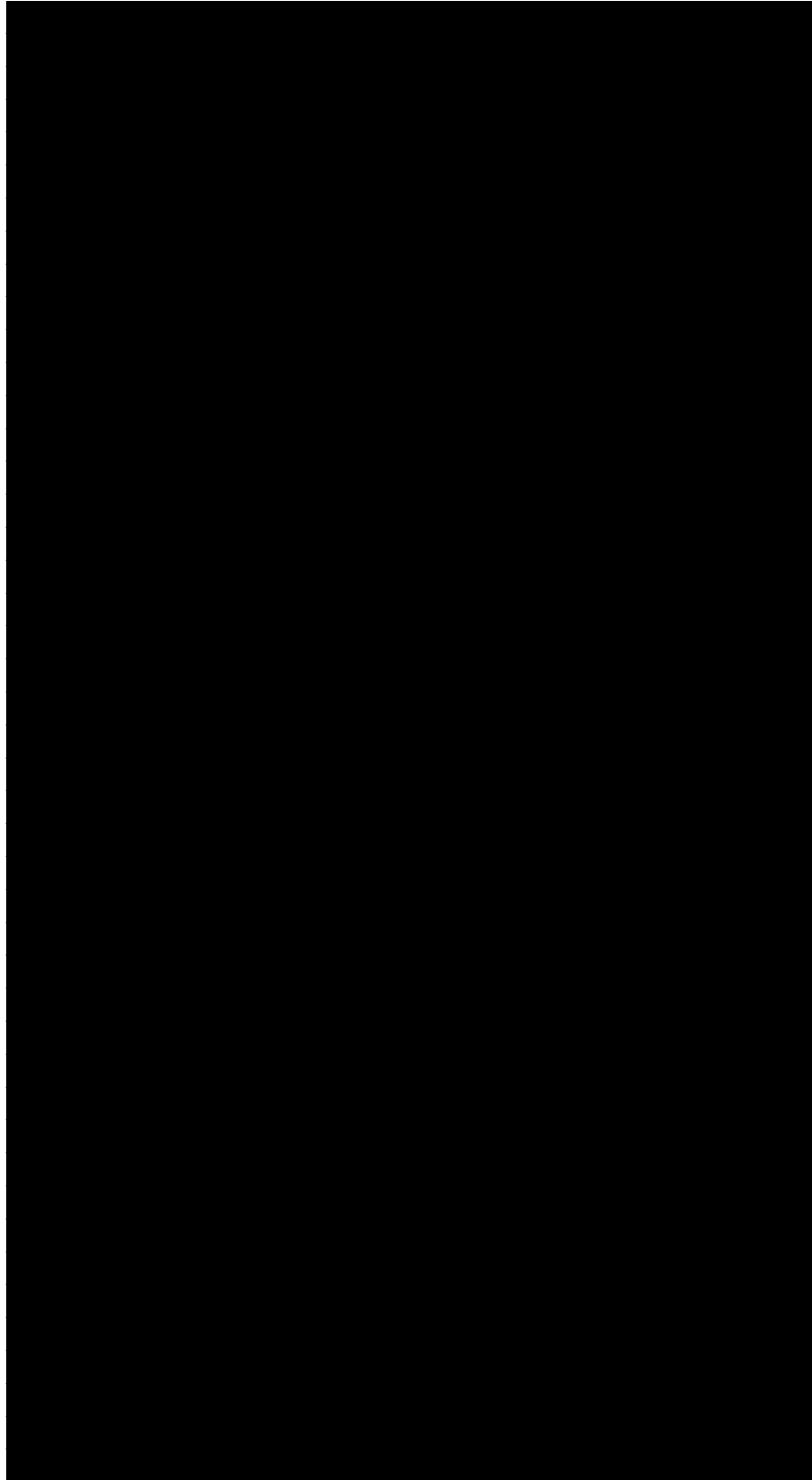
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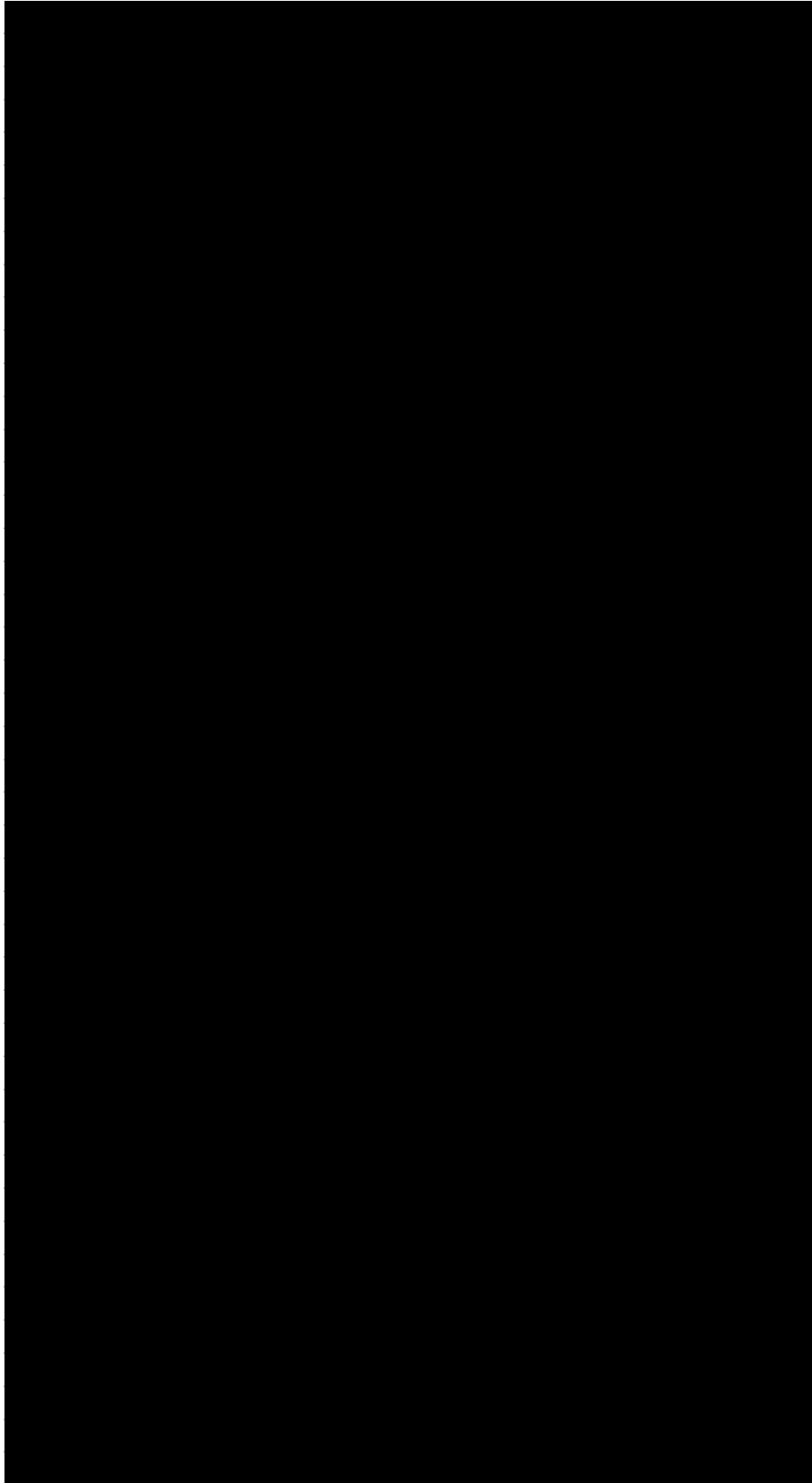
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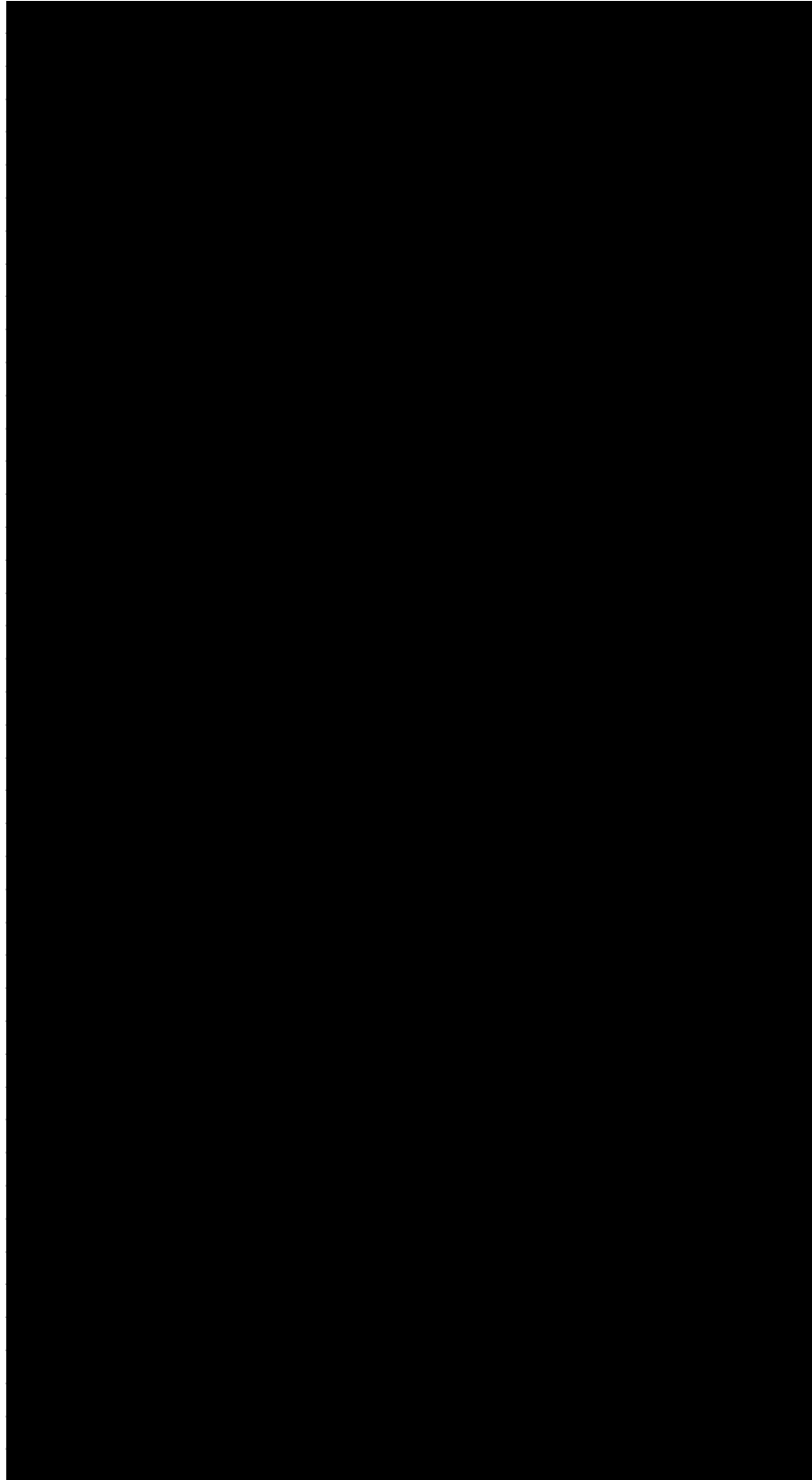
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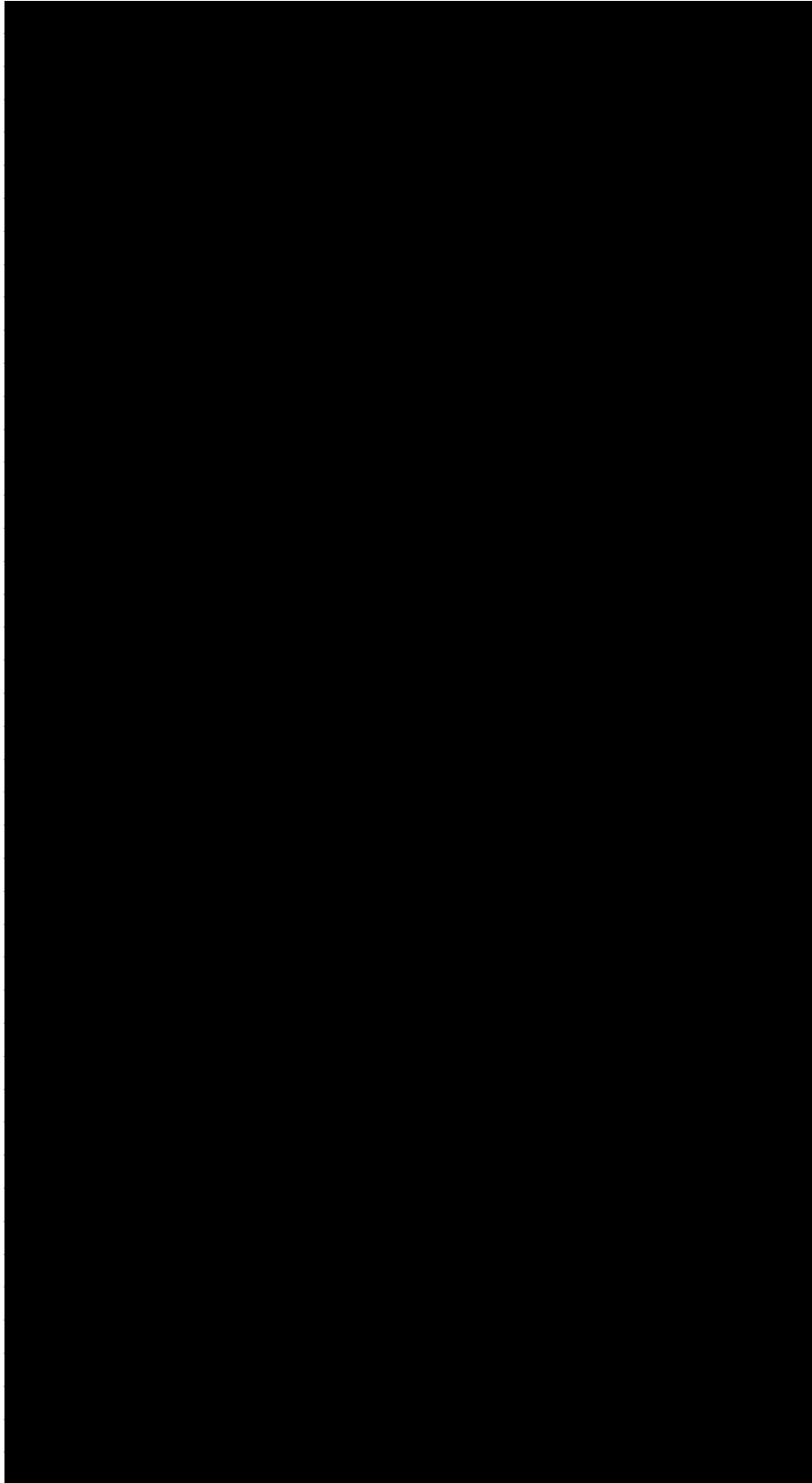
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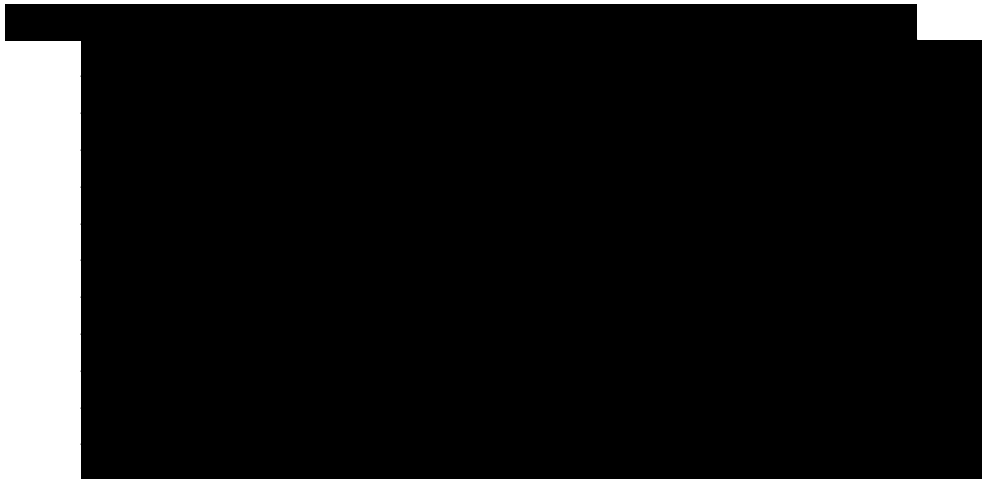
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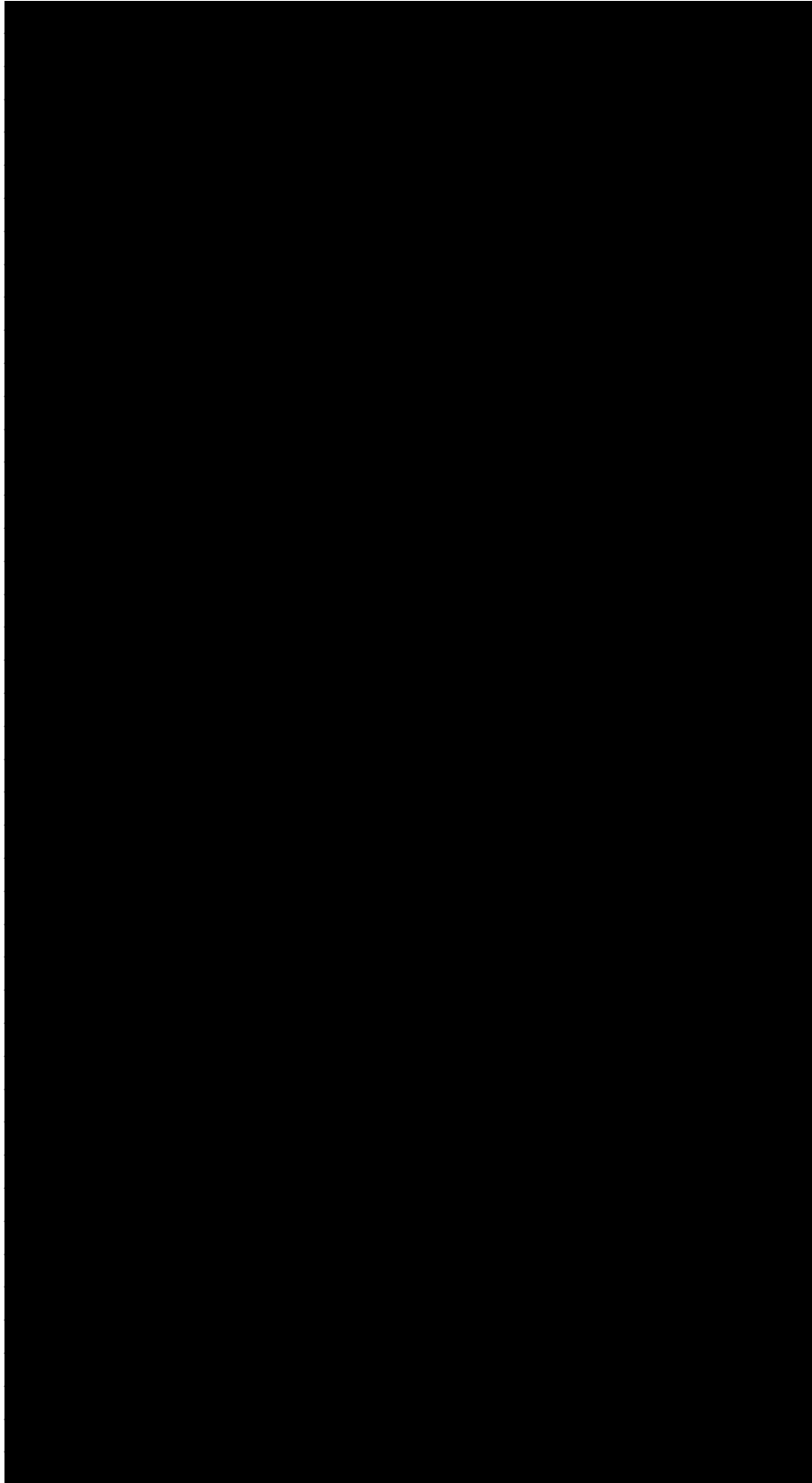
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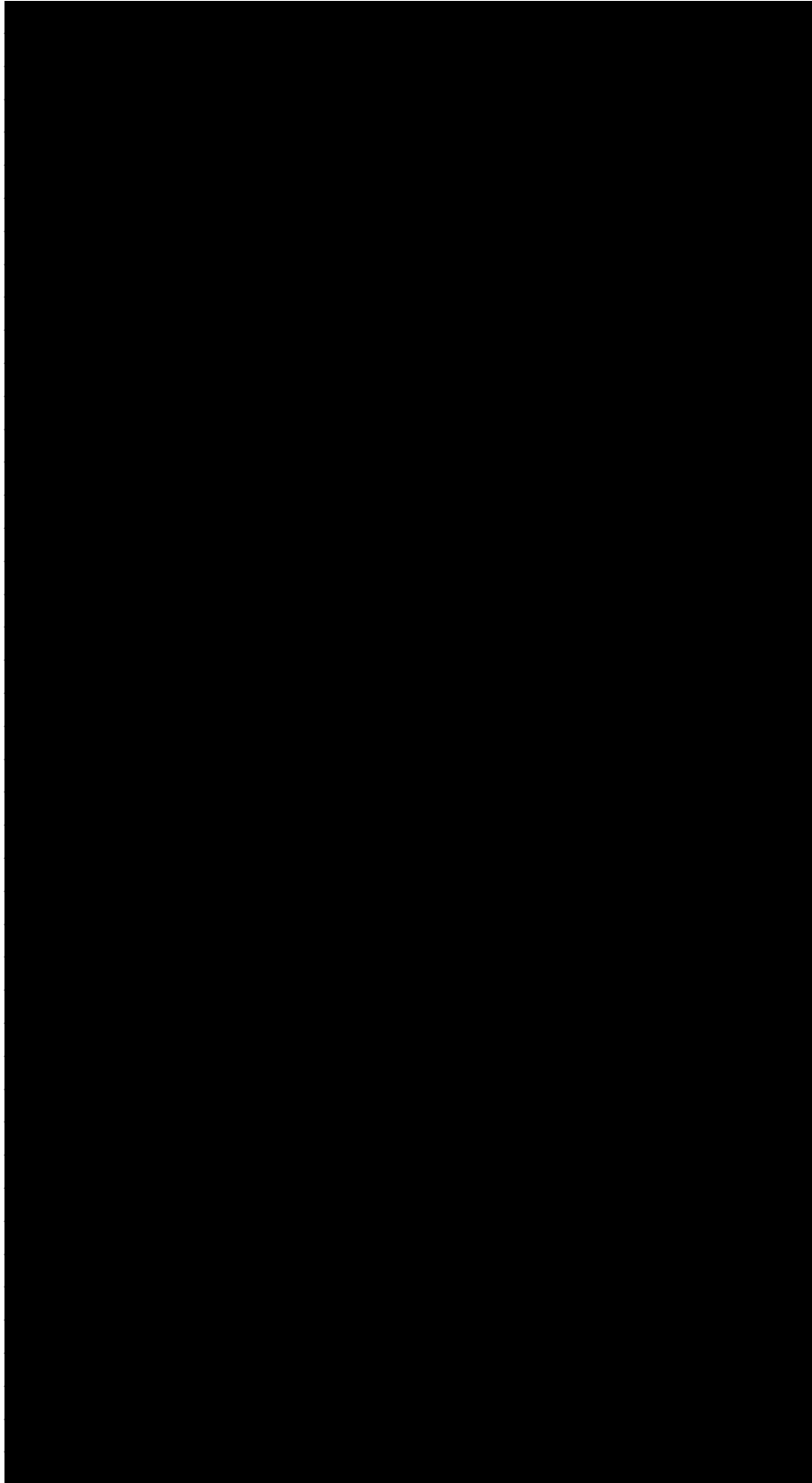
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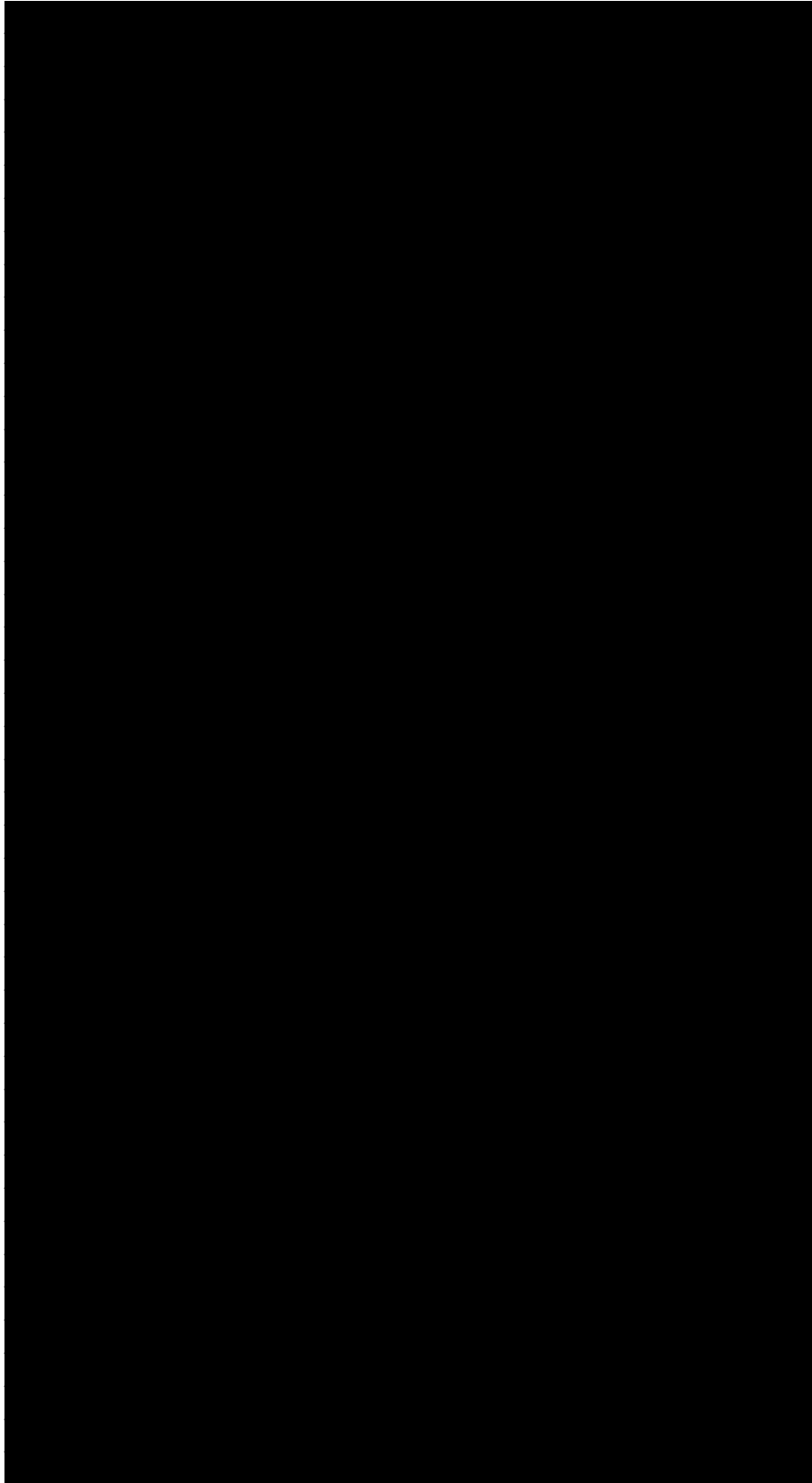
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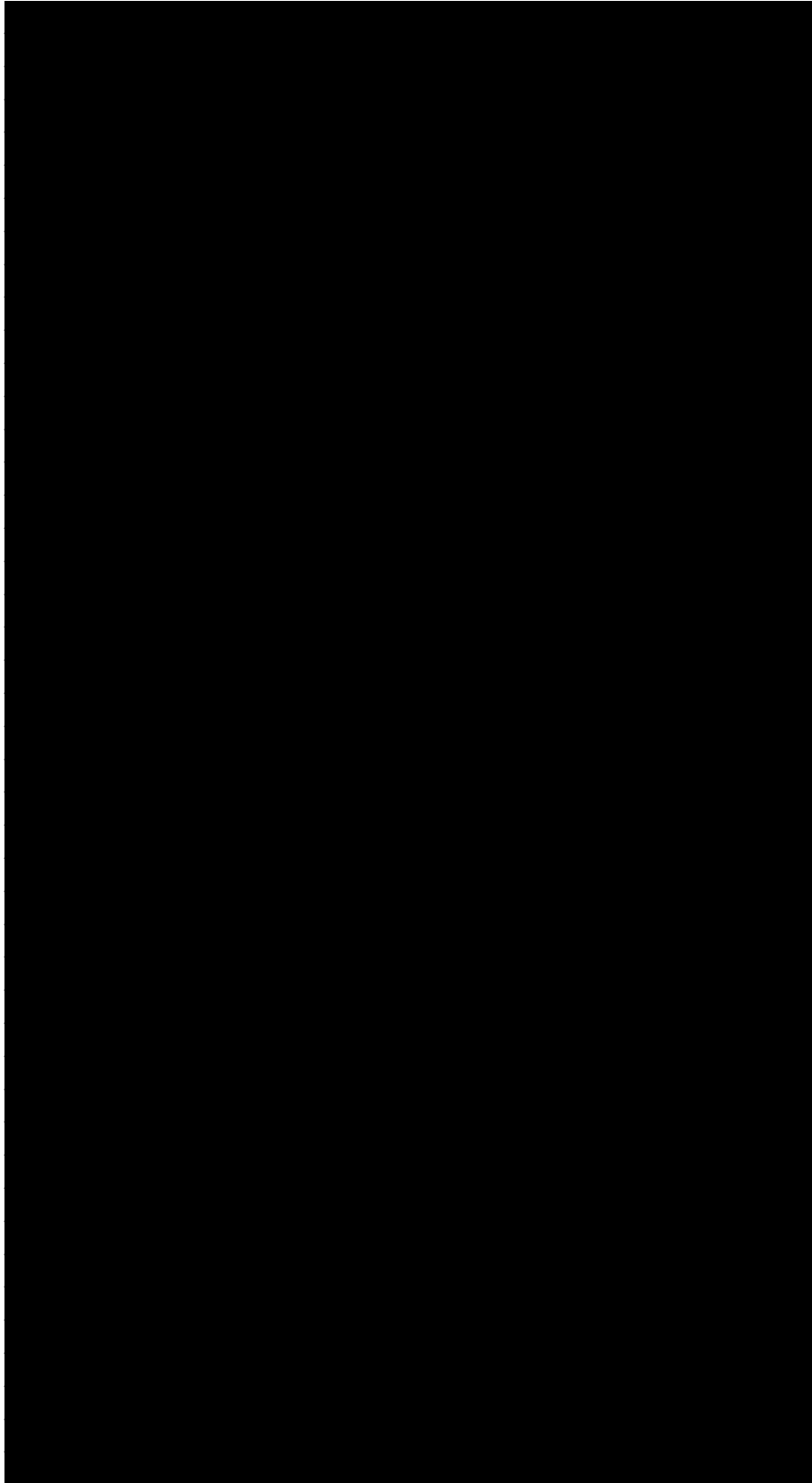
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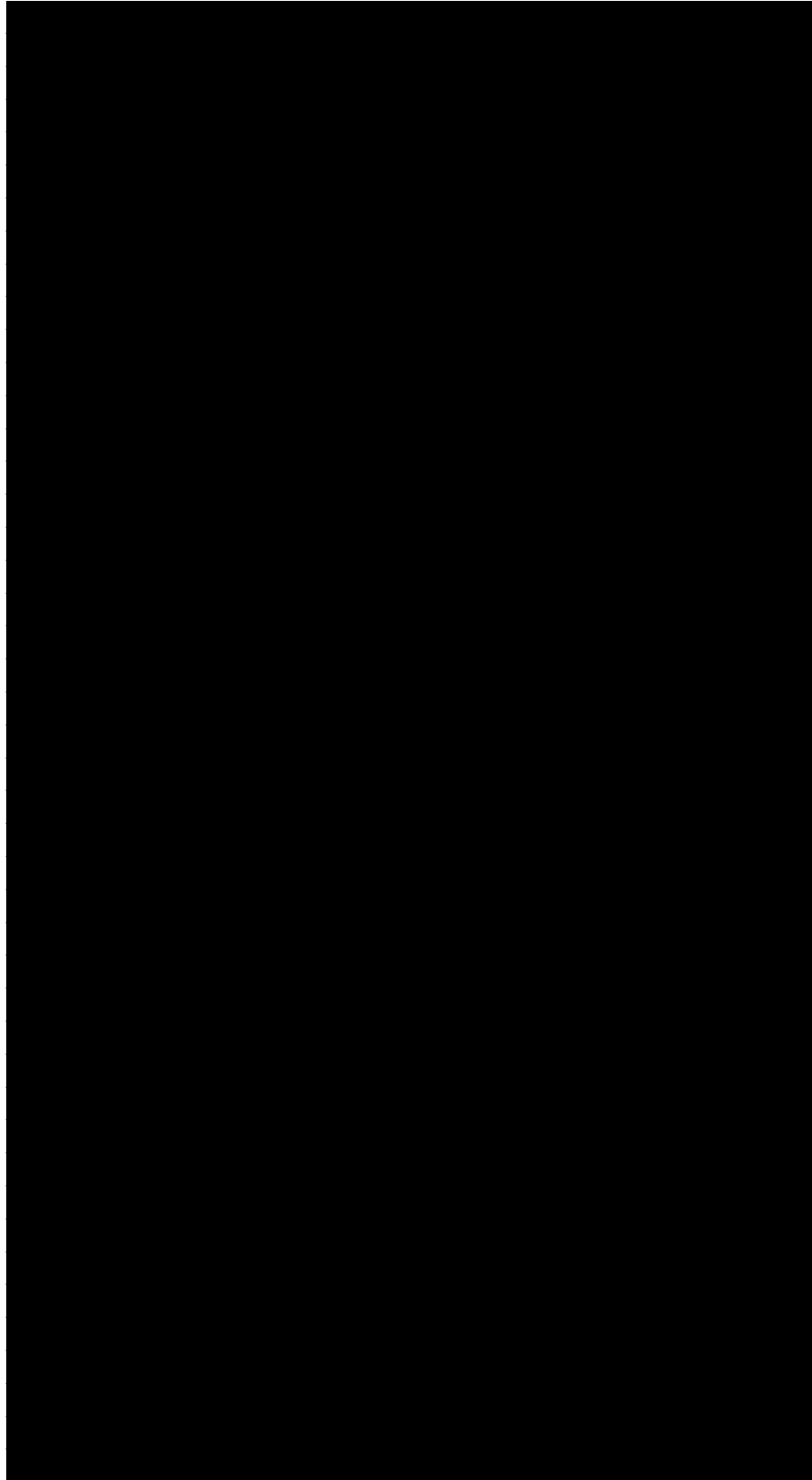
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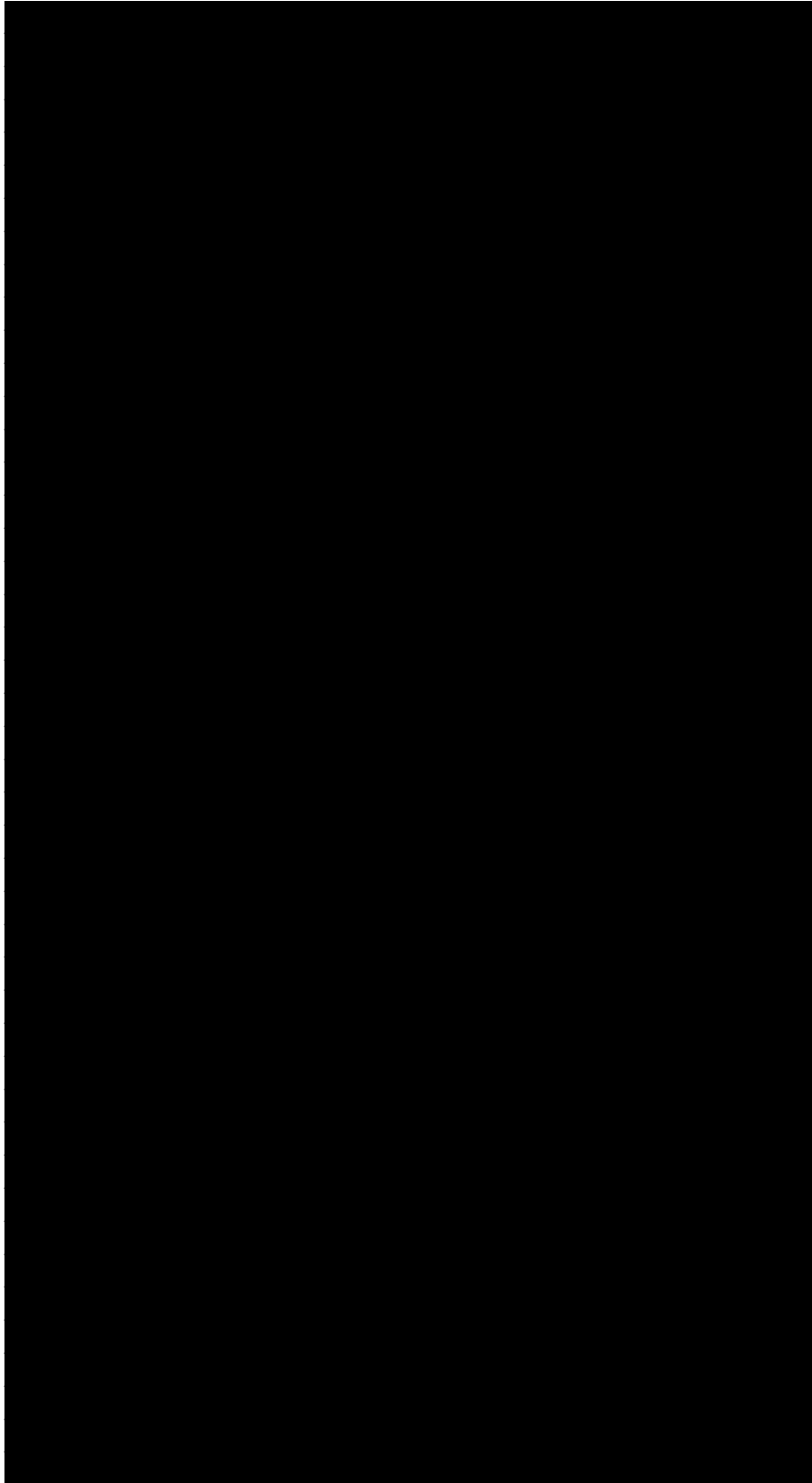


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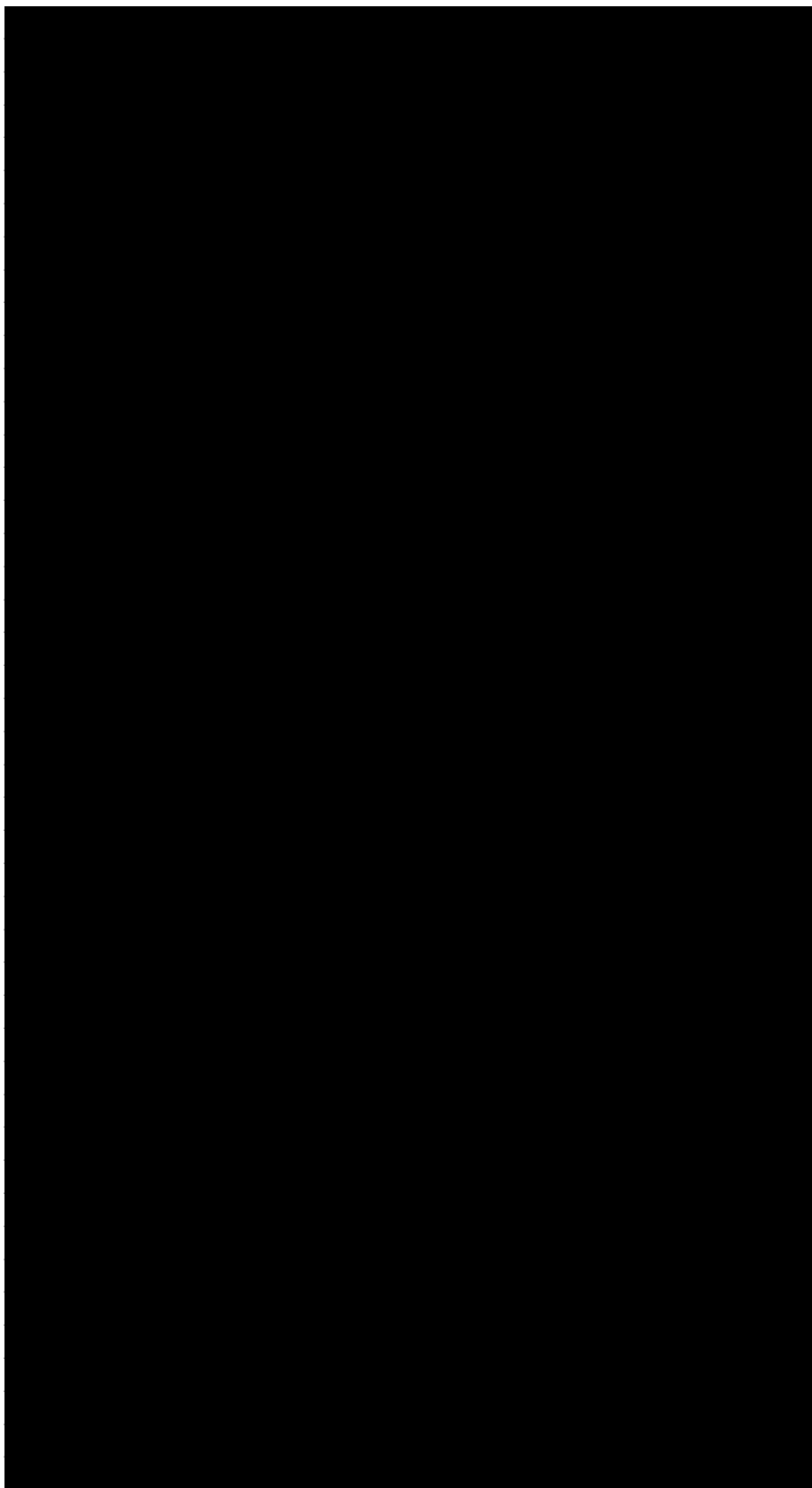


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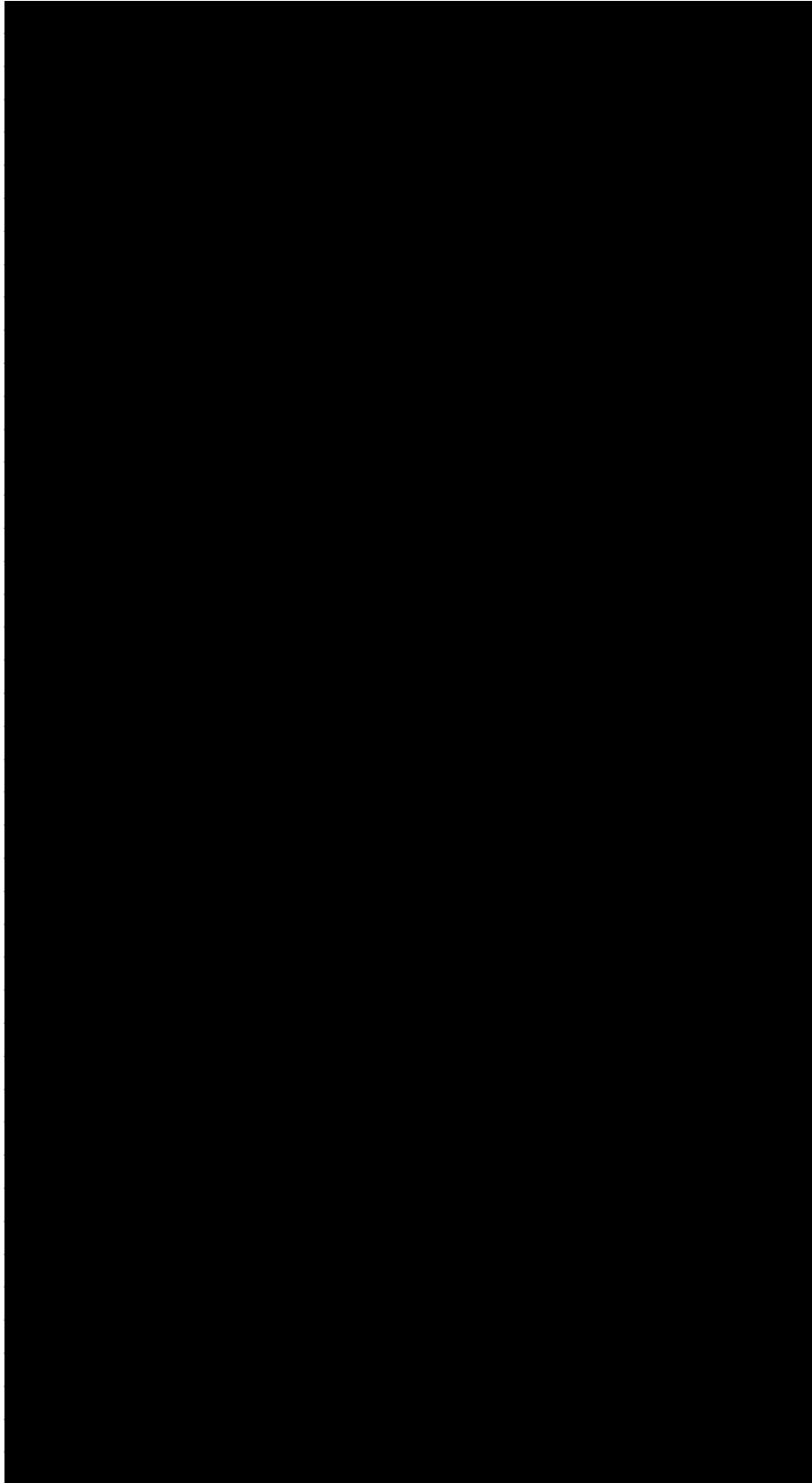




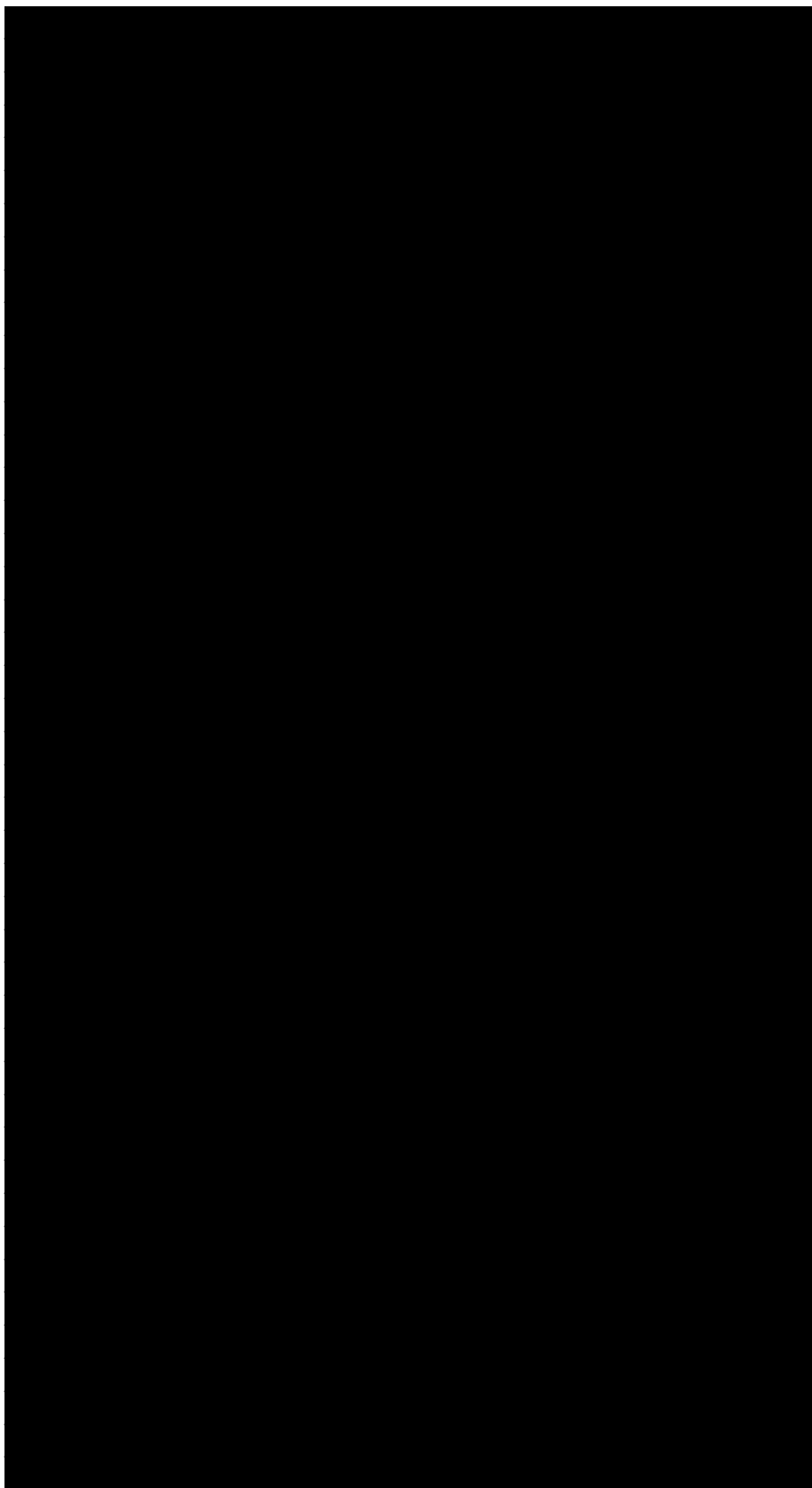
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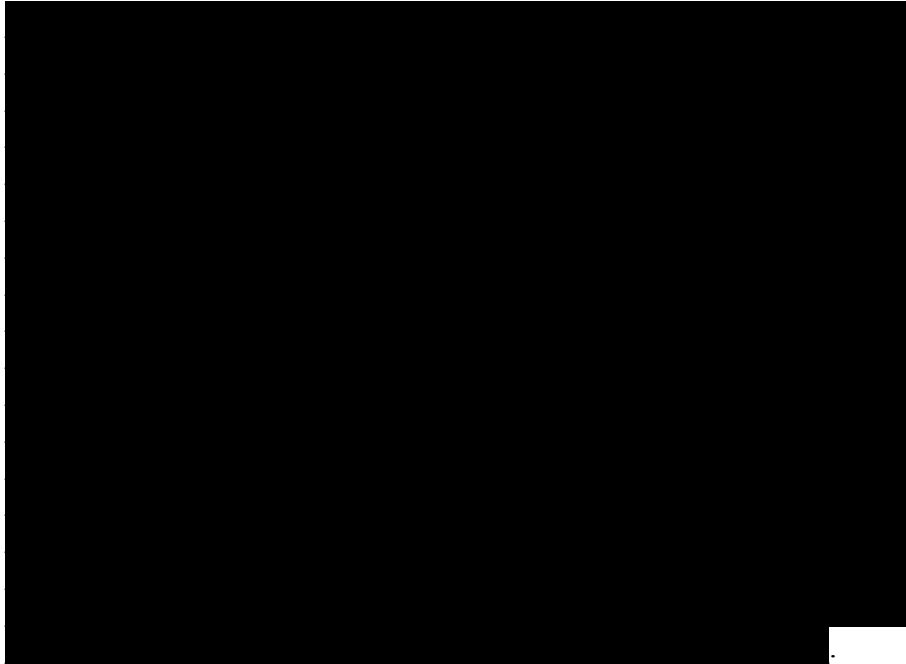
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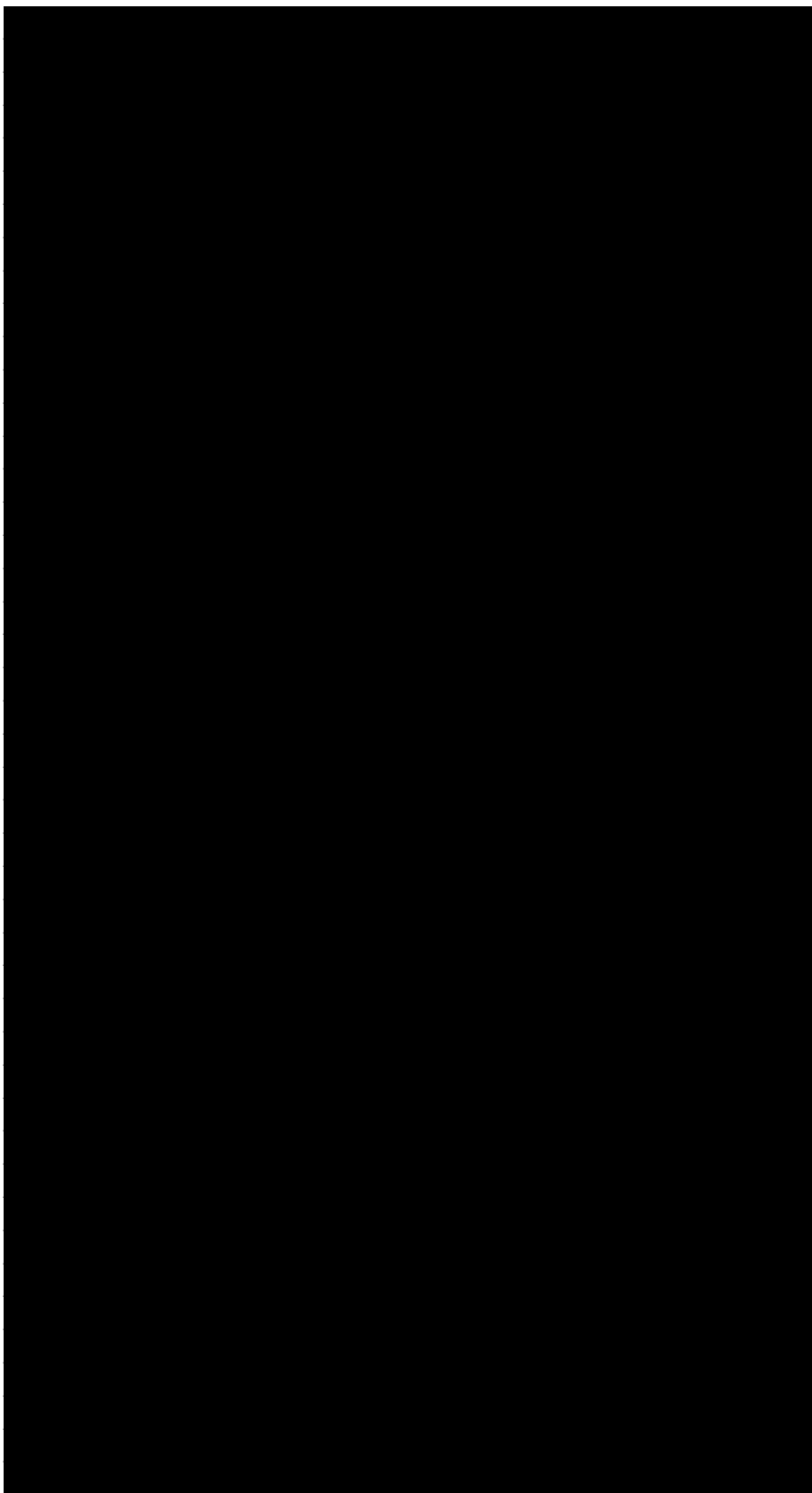


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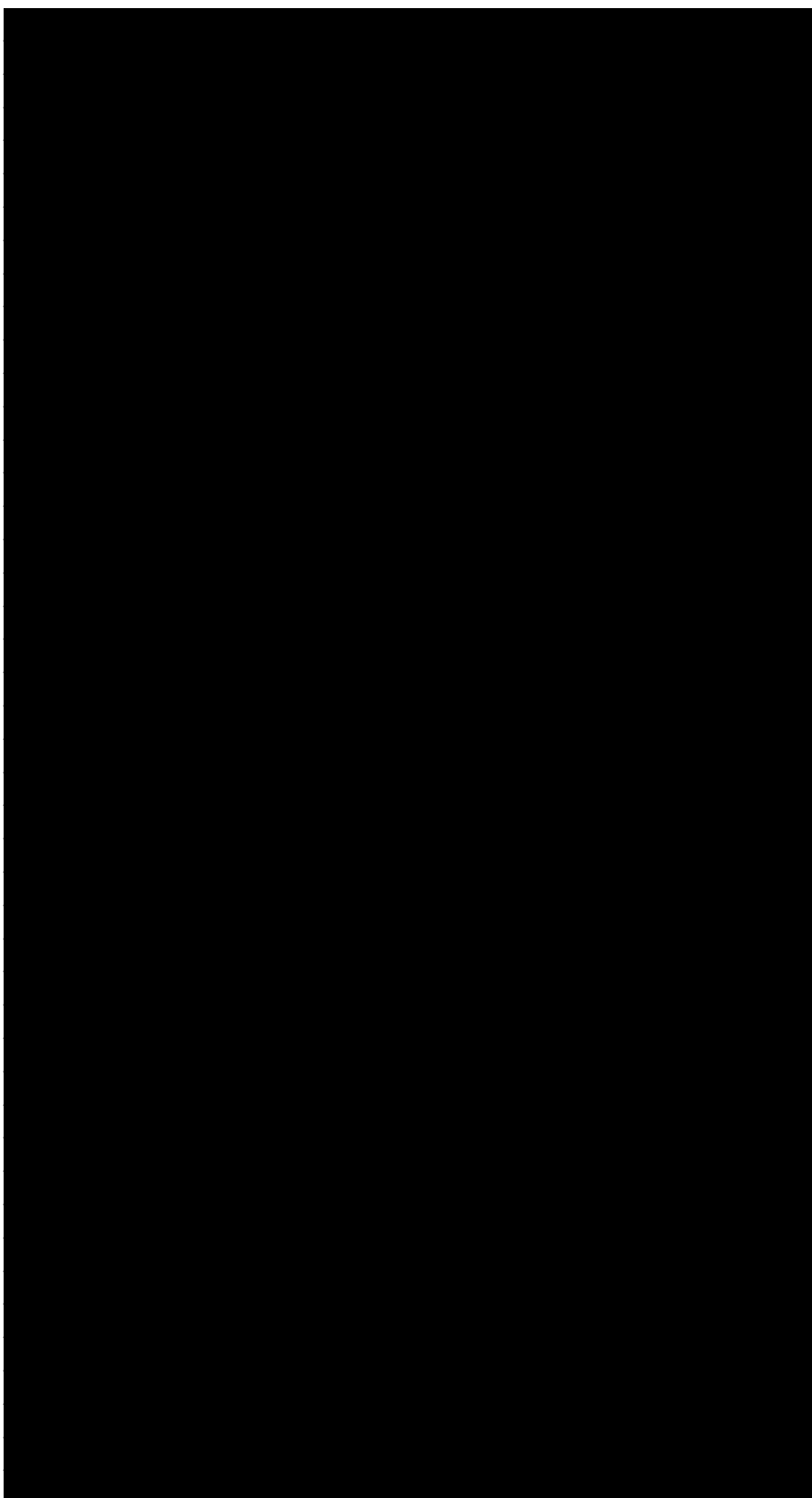


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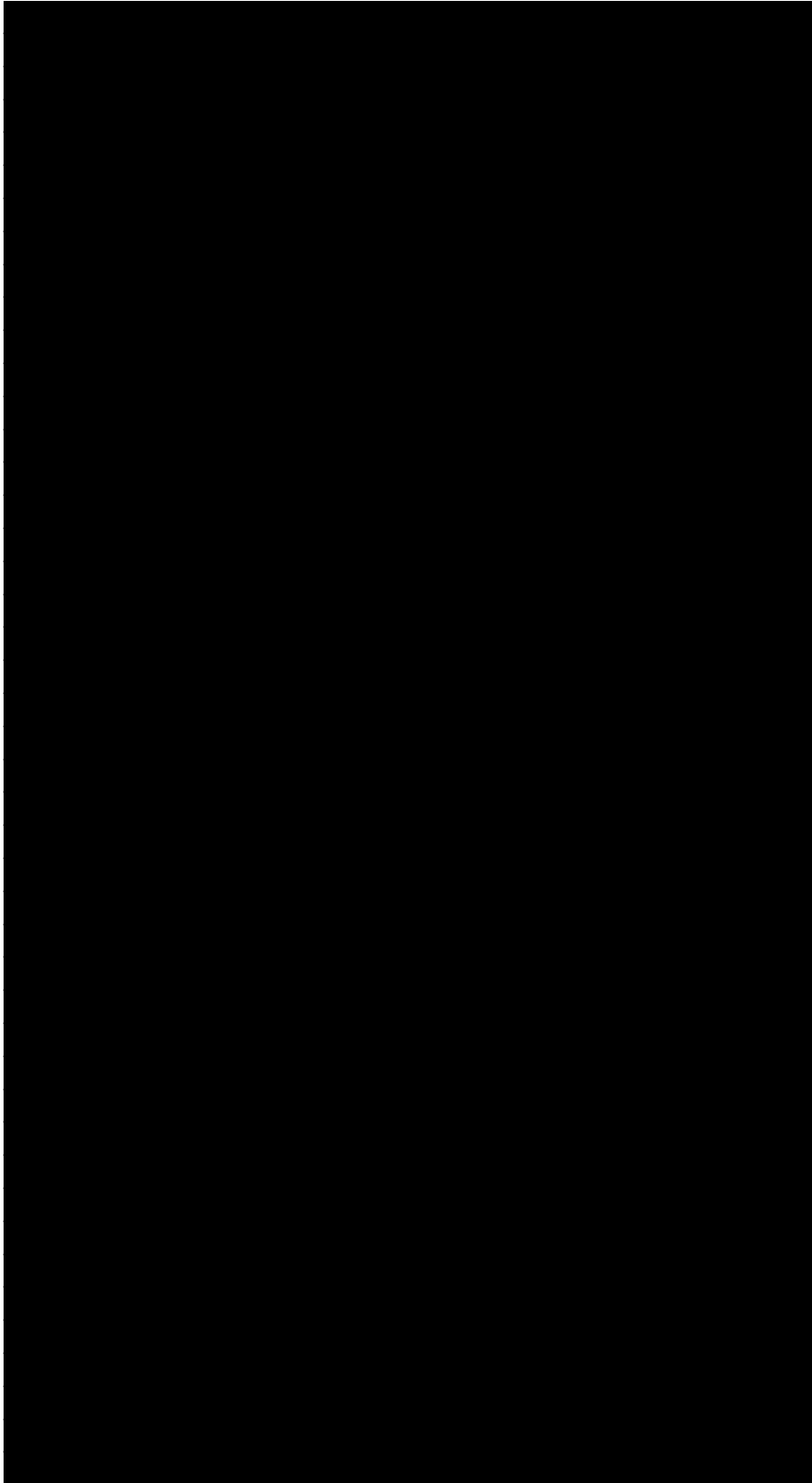




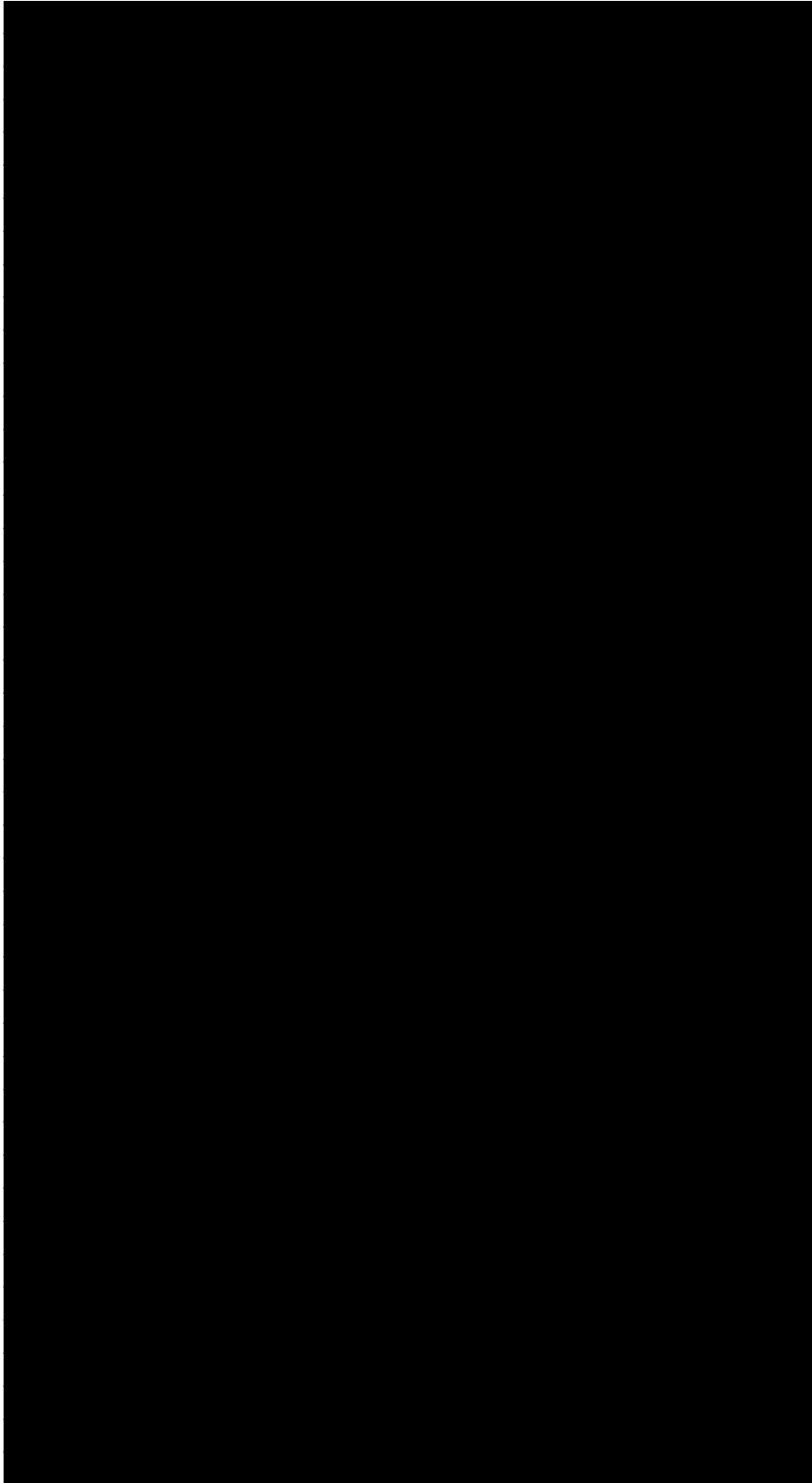
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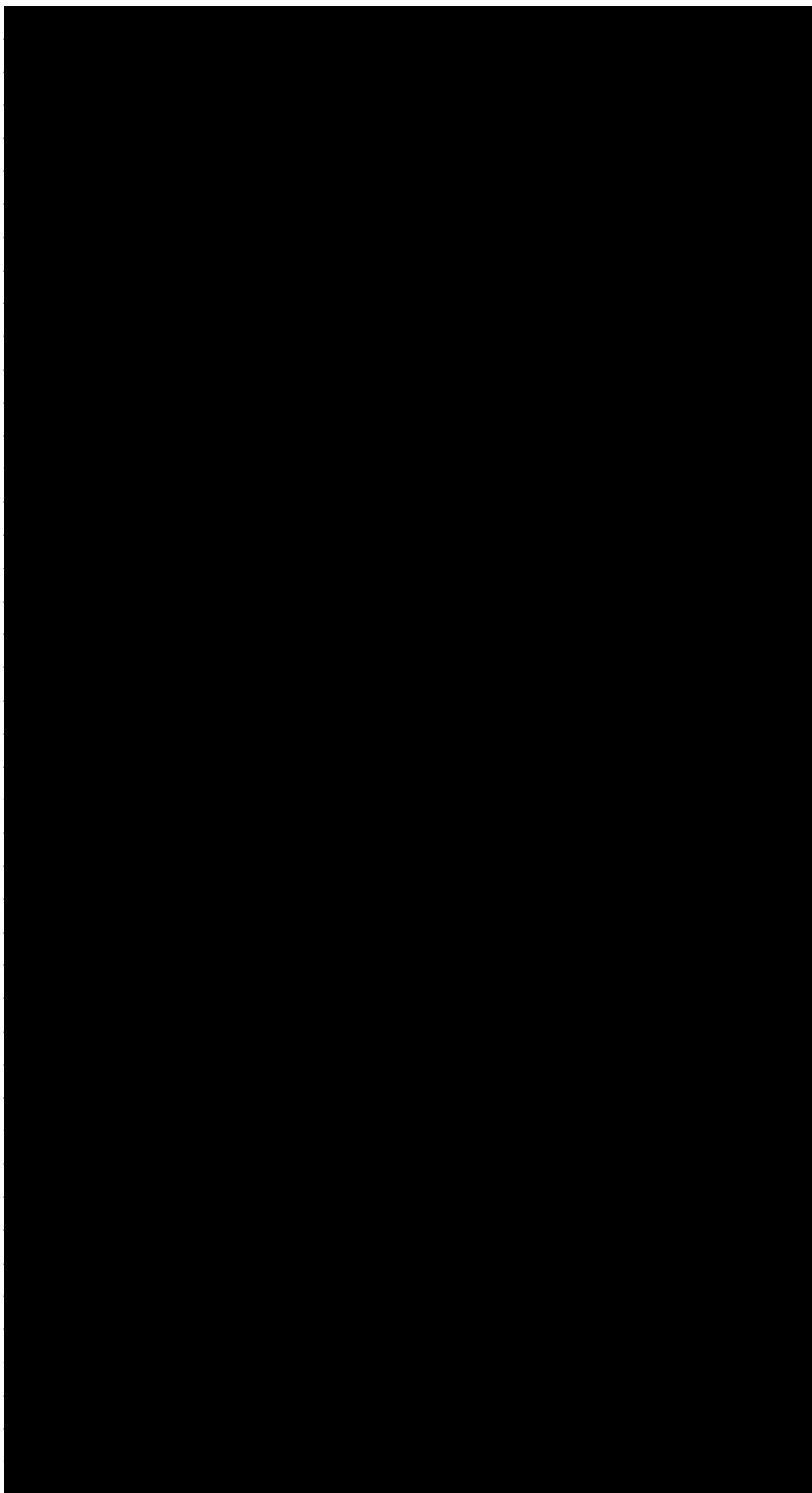


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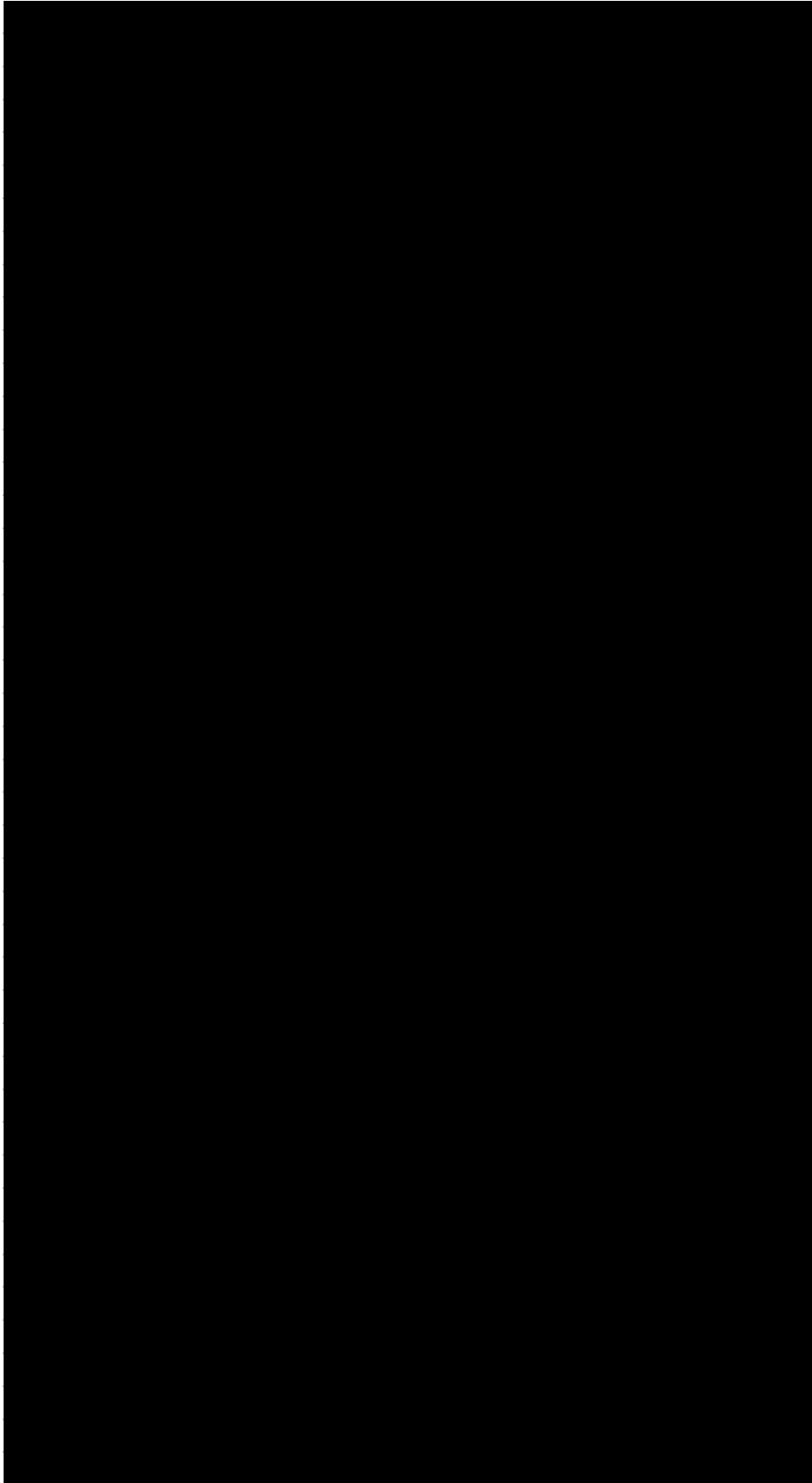


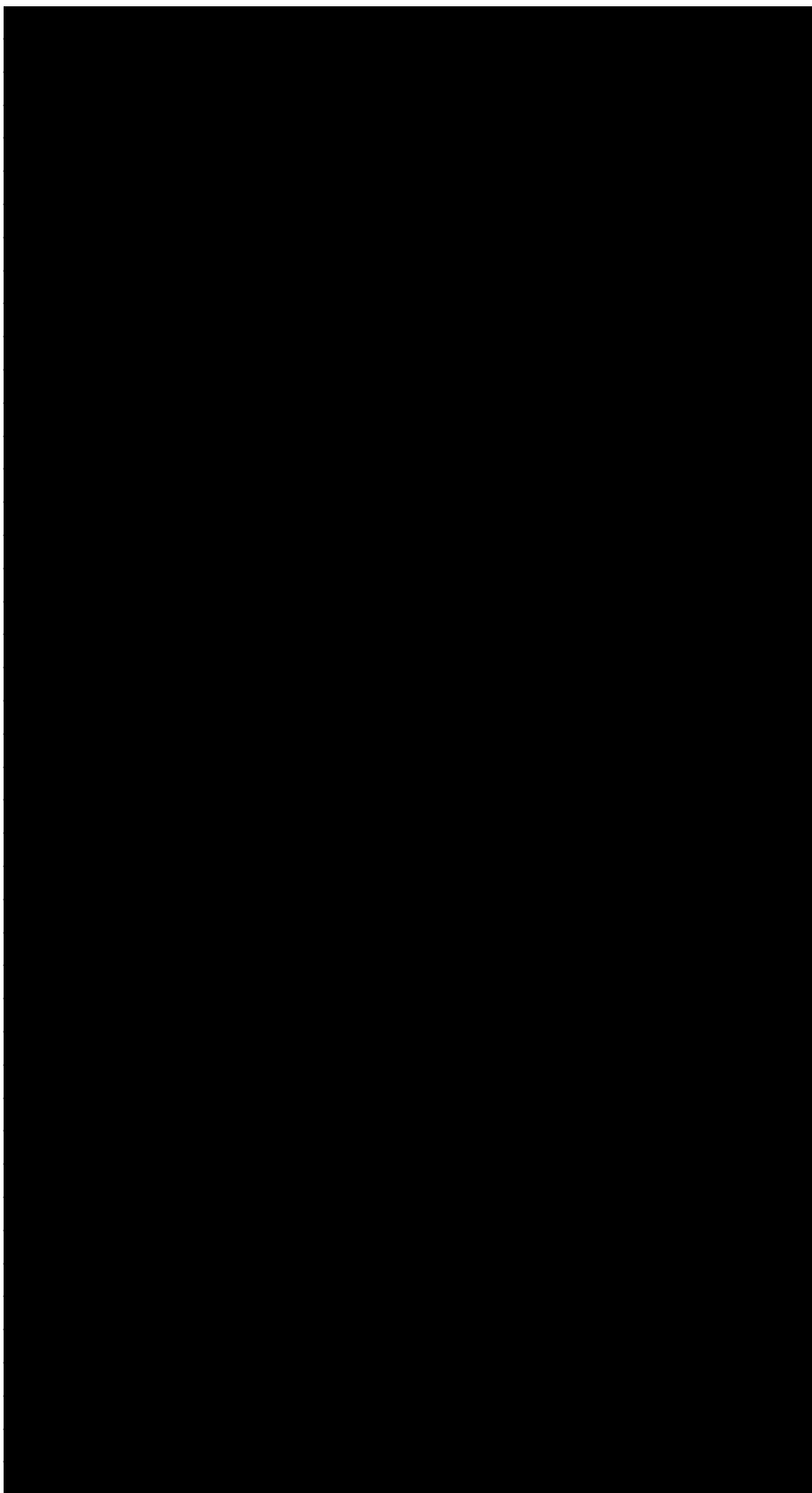
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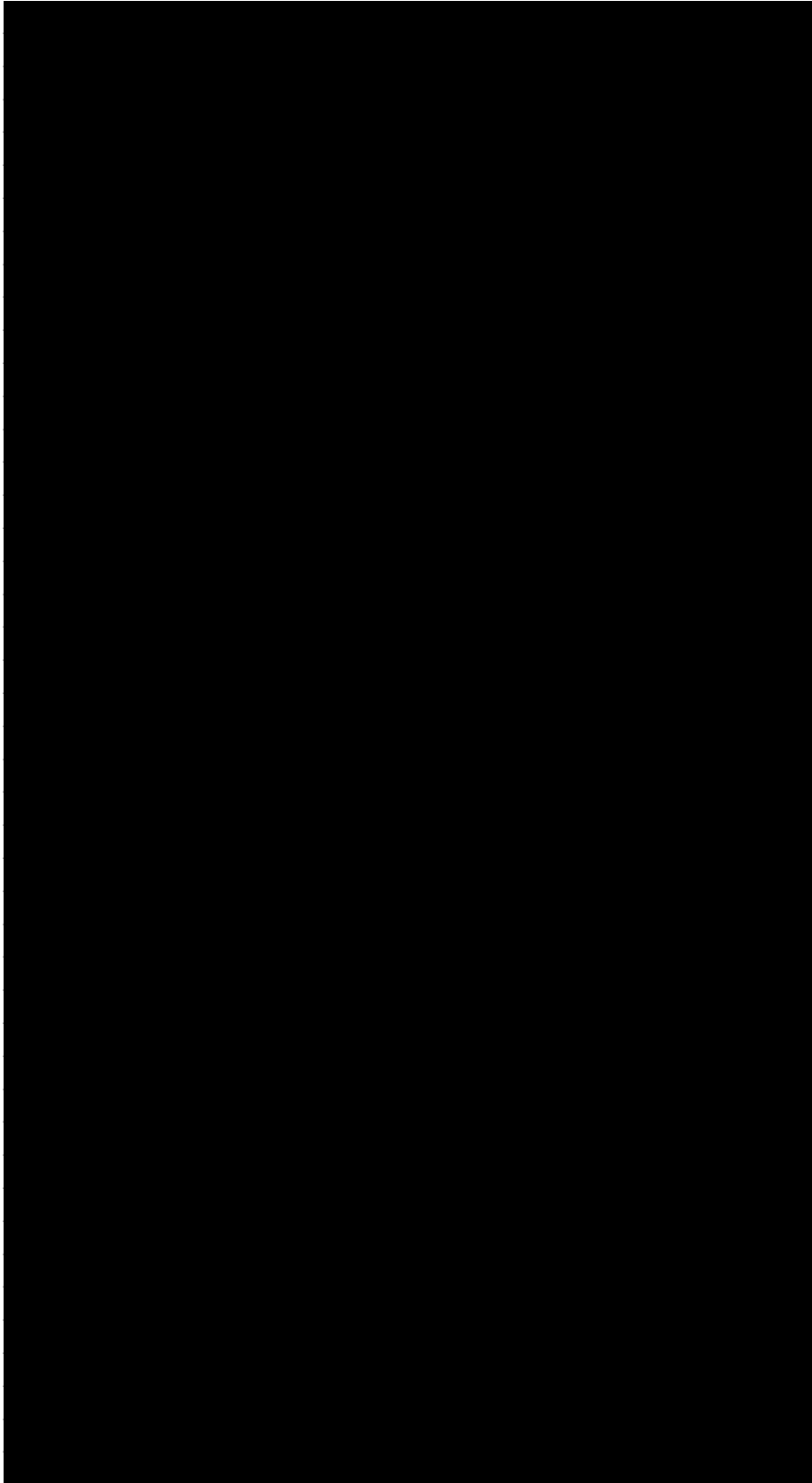


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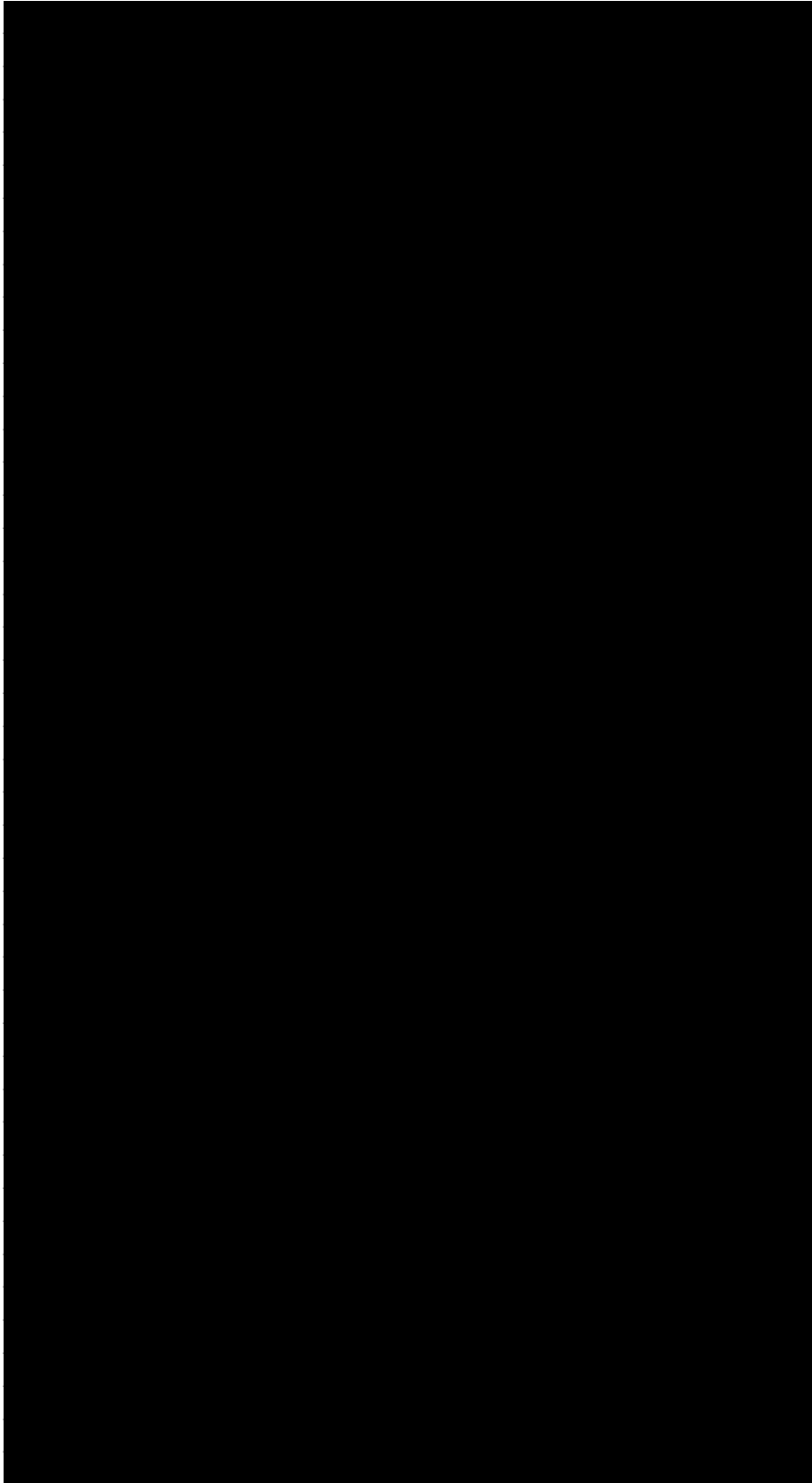




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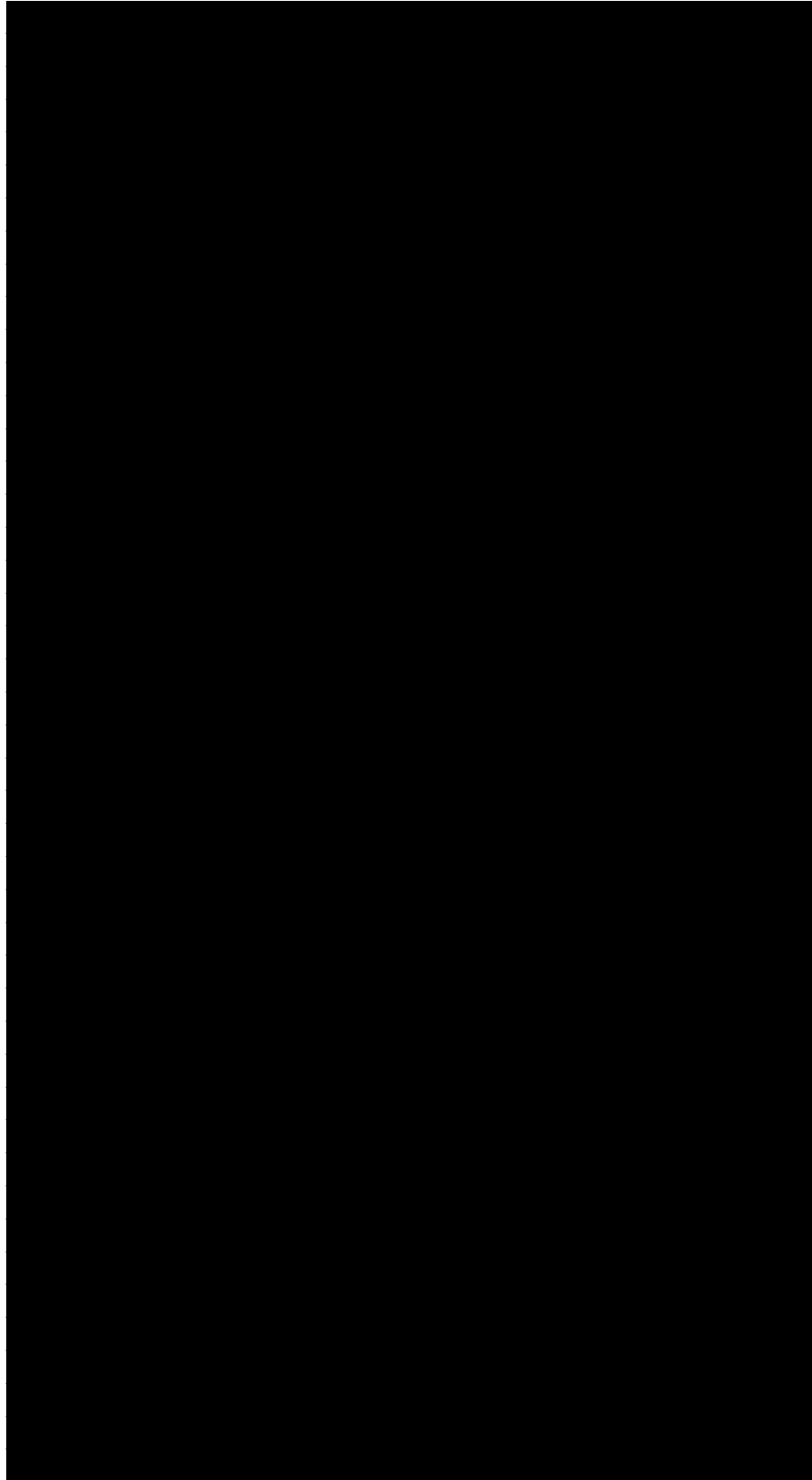
- (d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Section 438.400 of 42 CFR Subpart F provides in part:

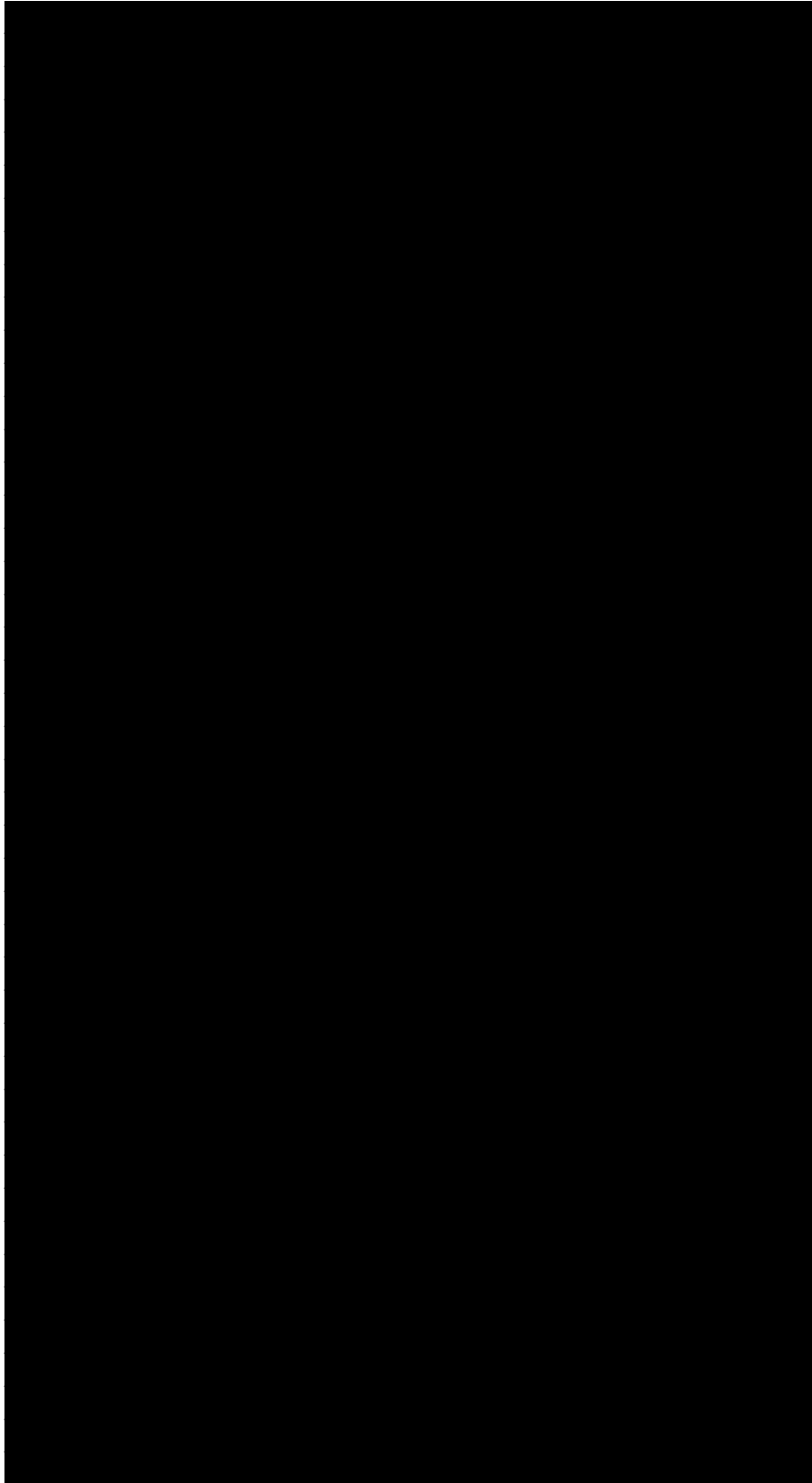
- (a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.



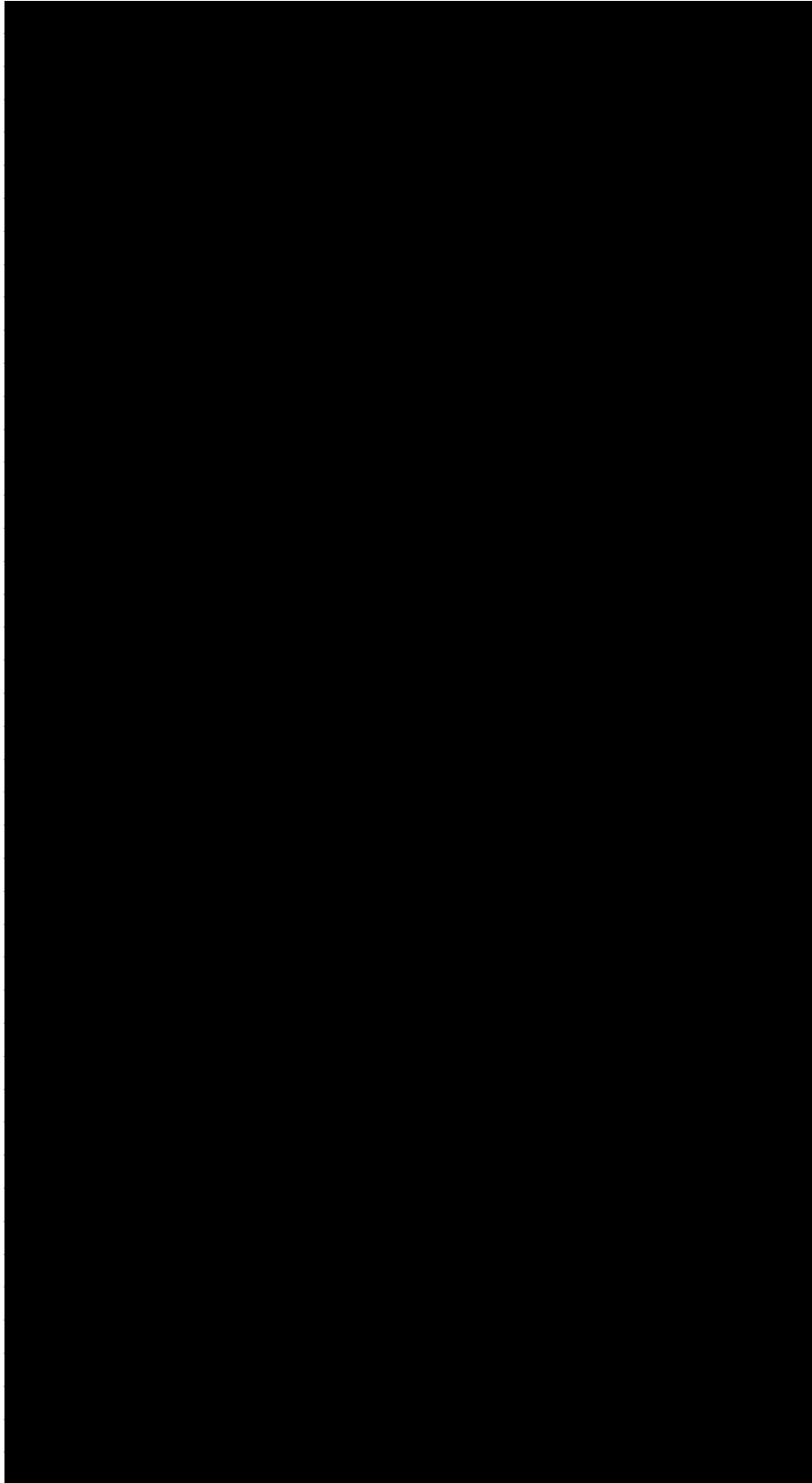
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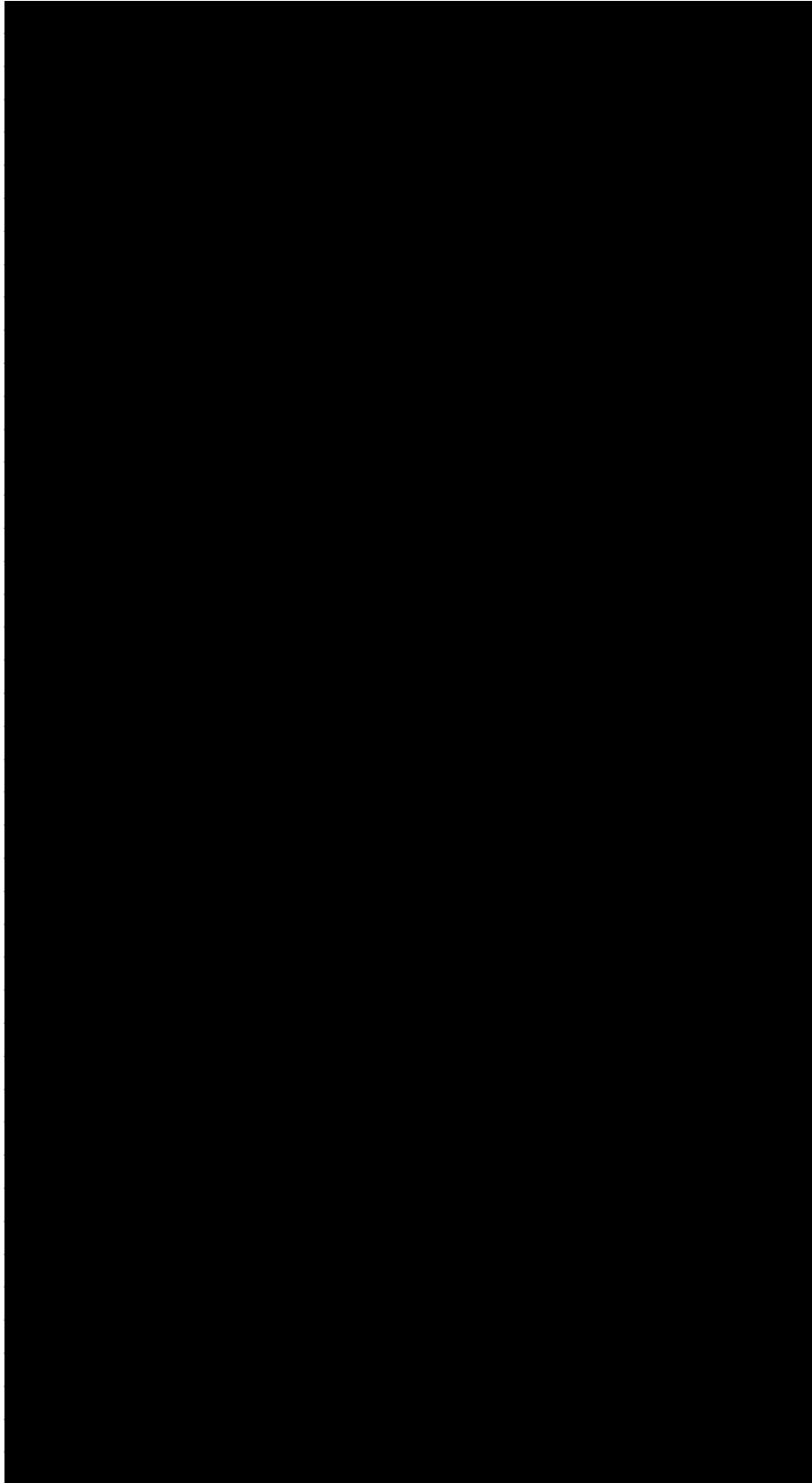
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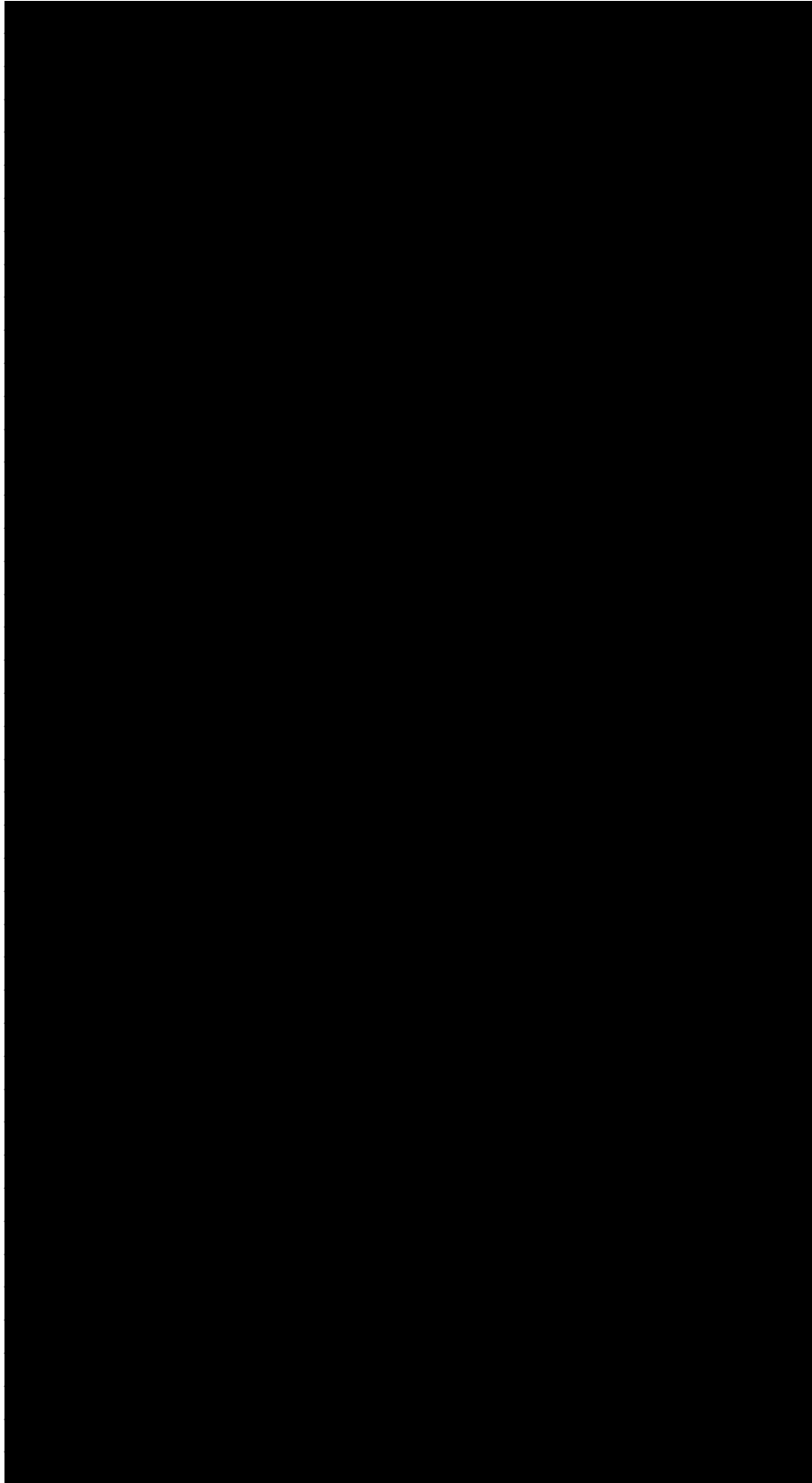
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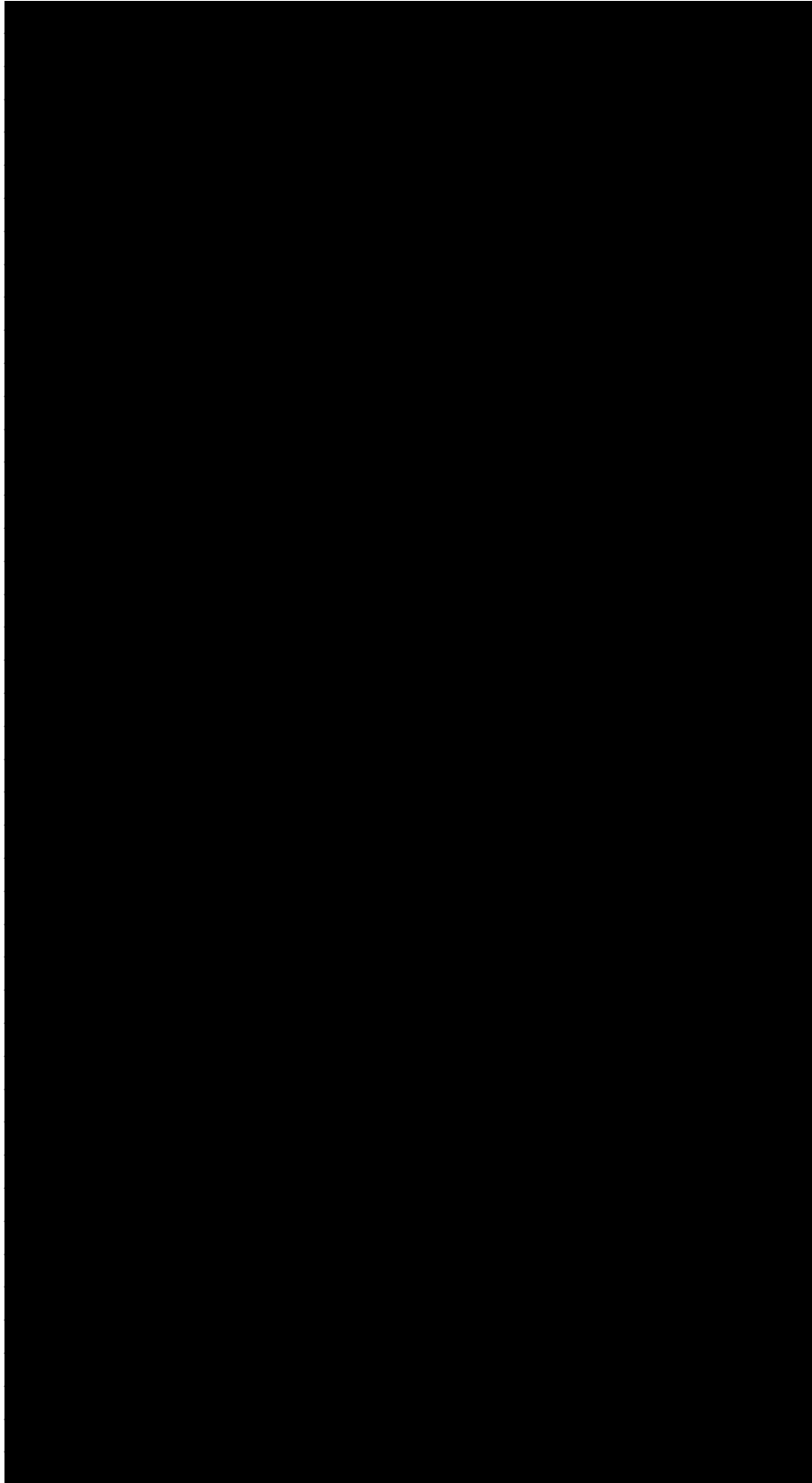


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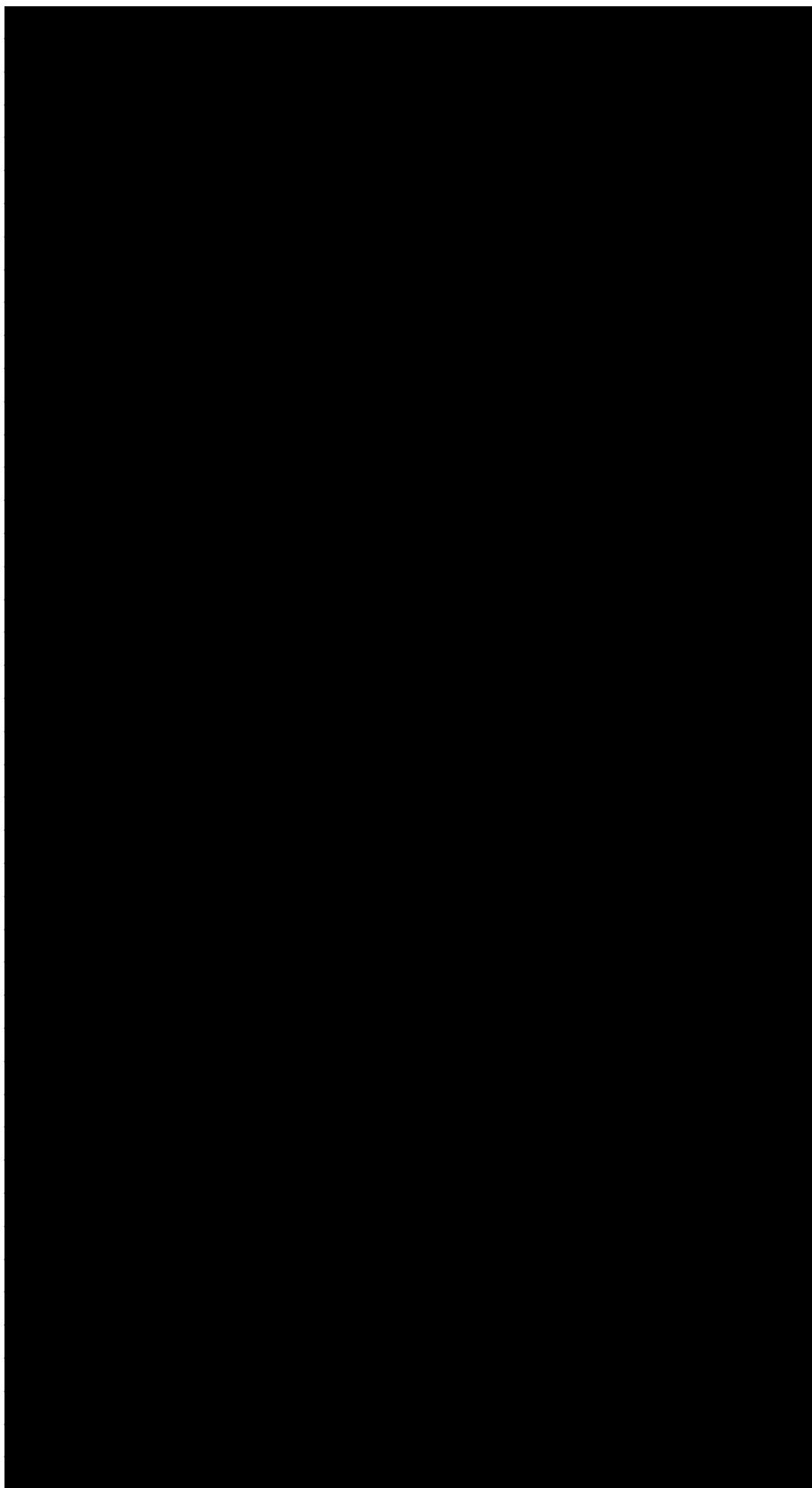


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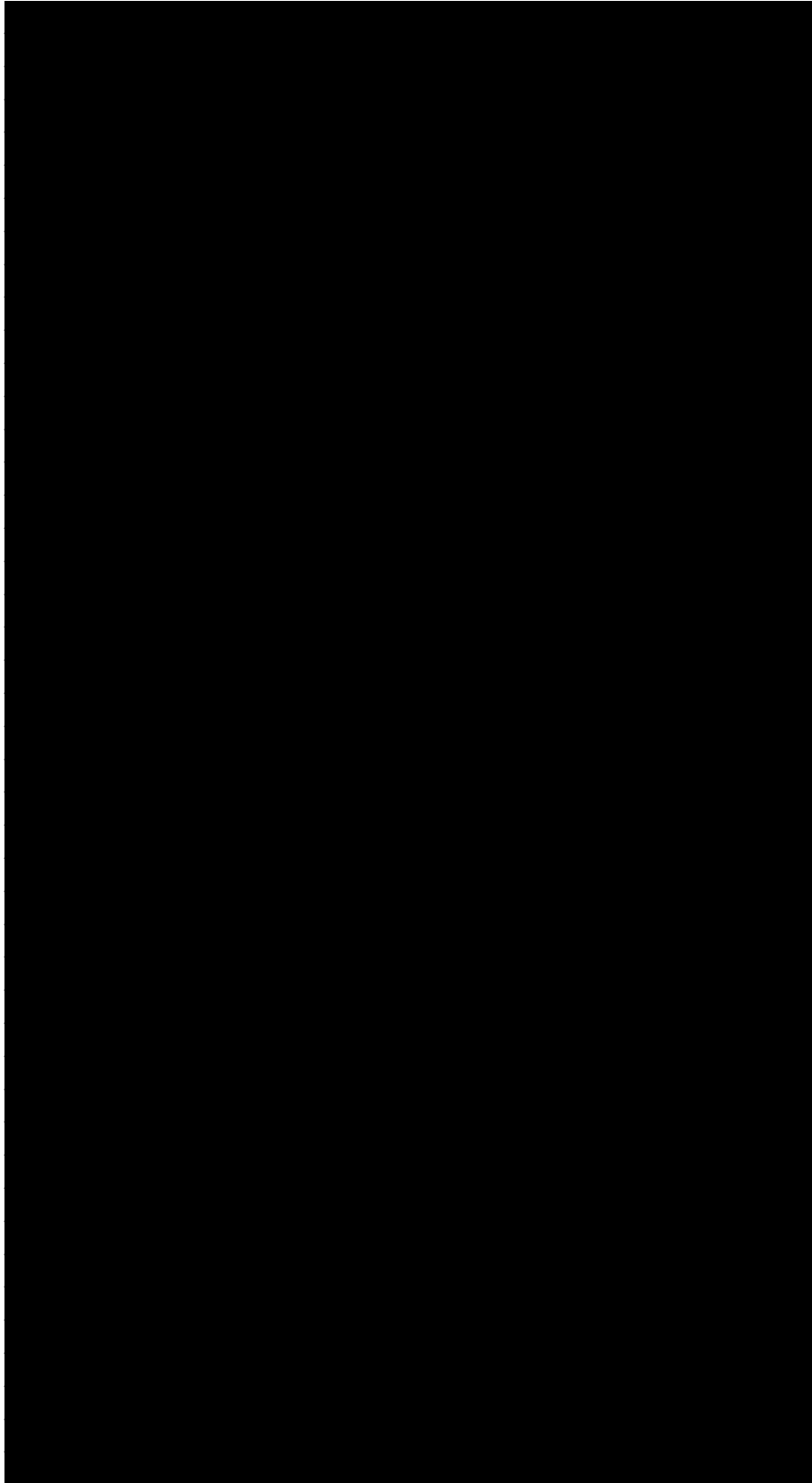




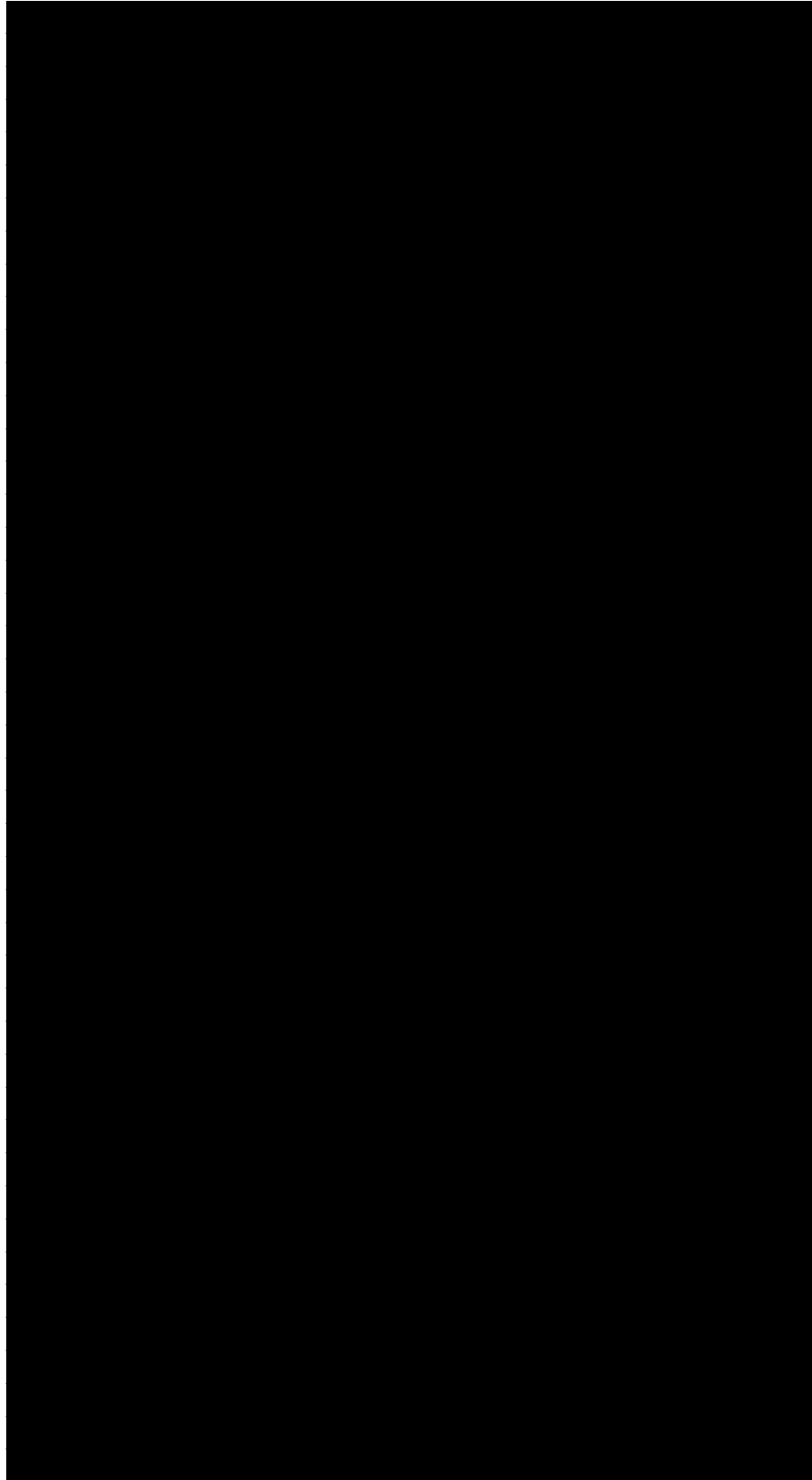
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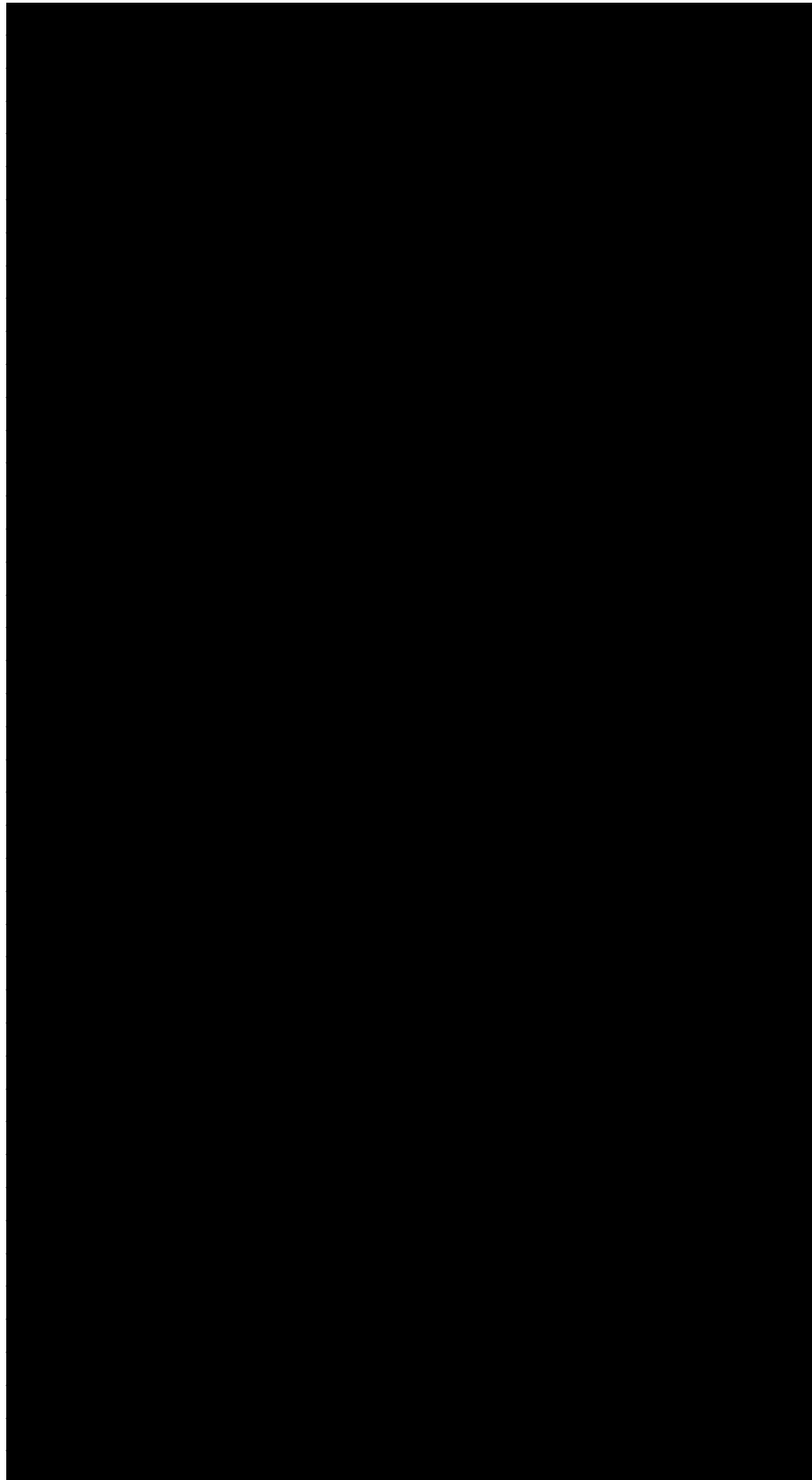
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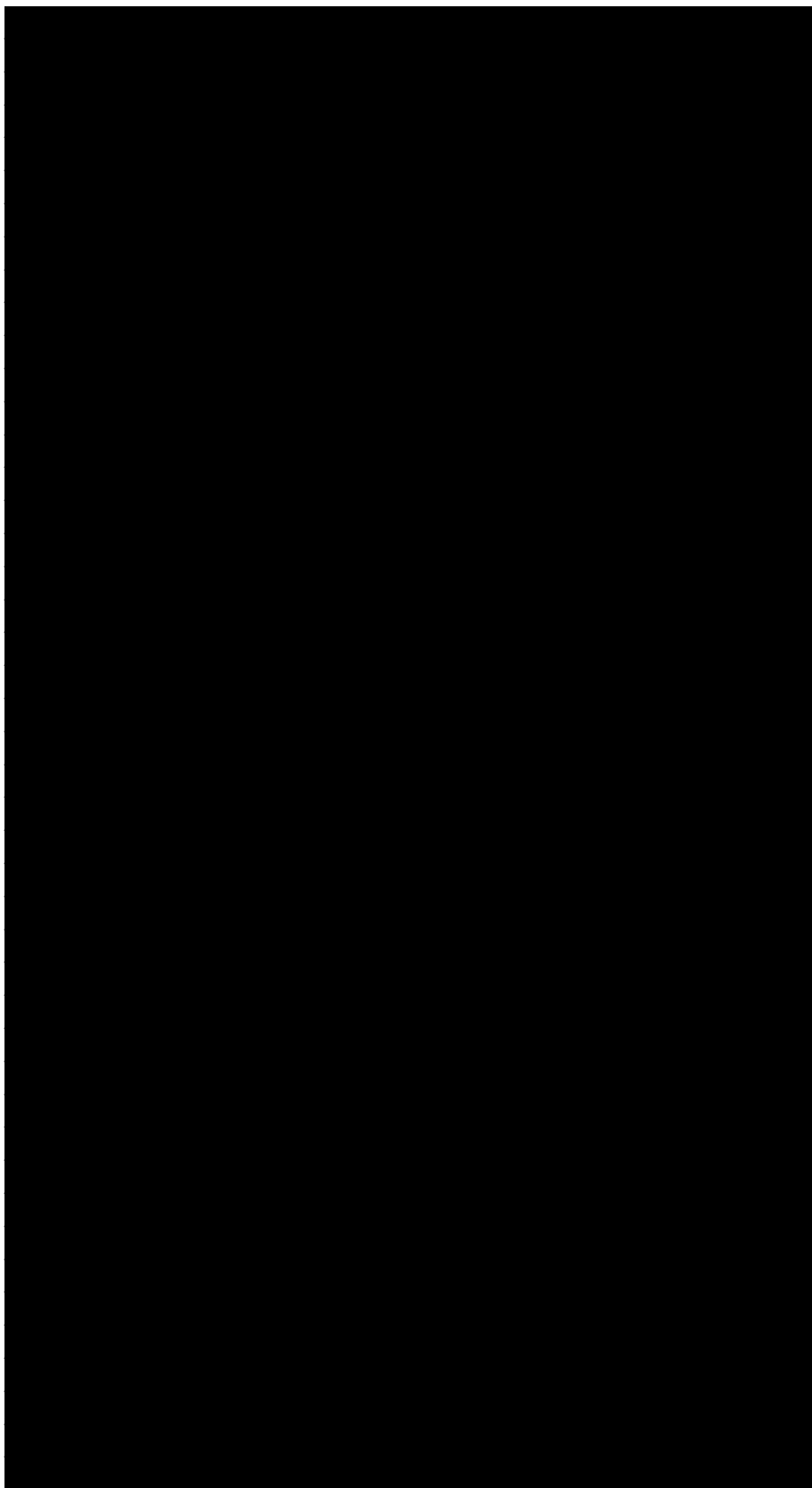


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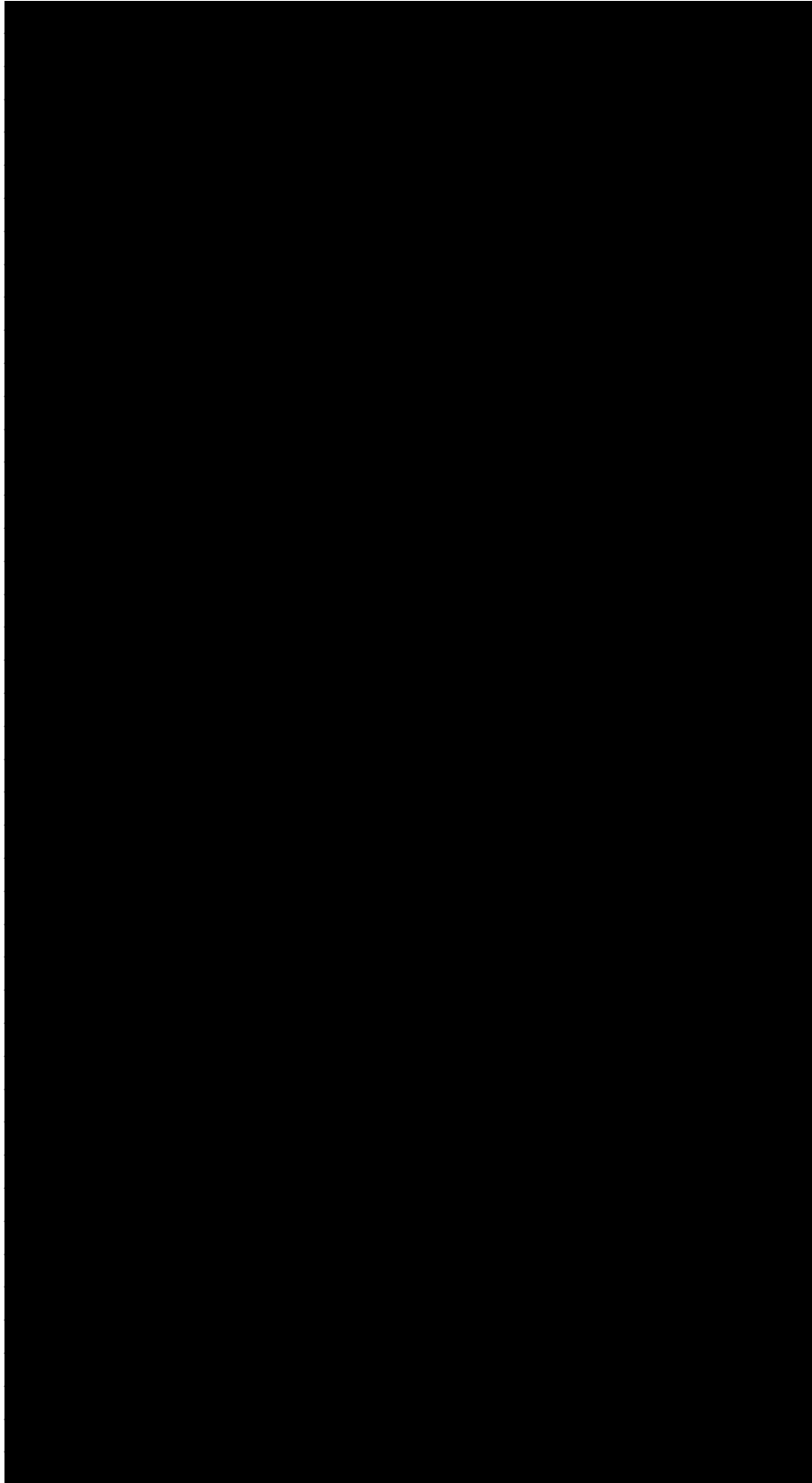


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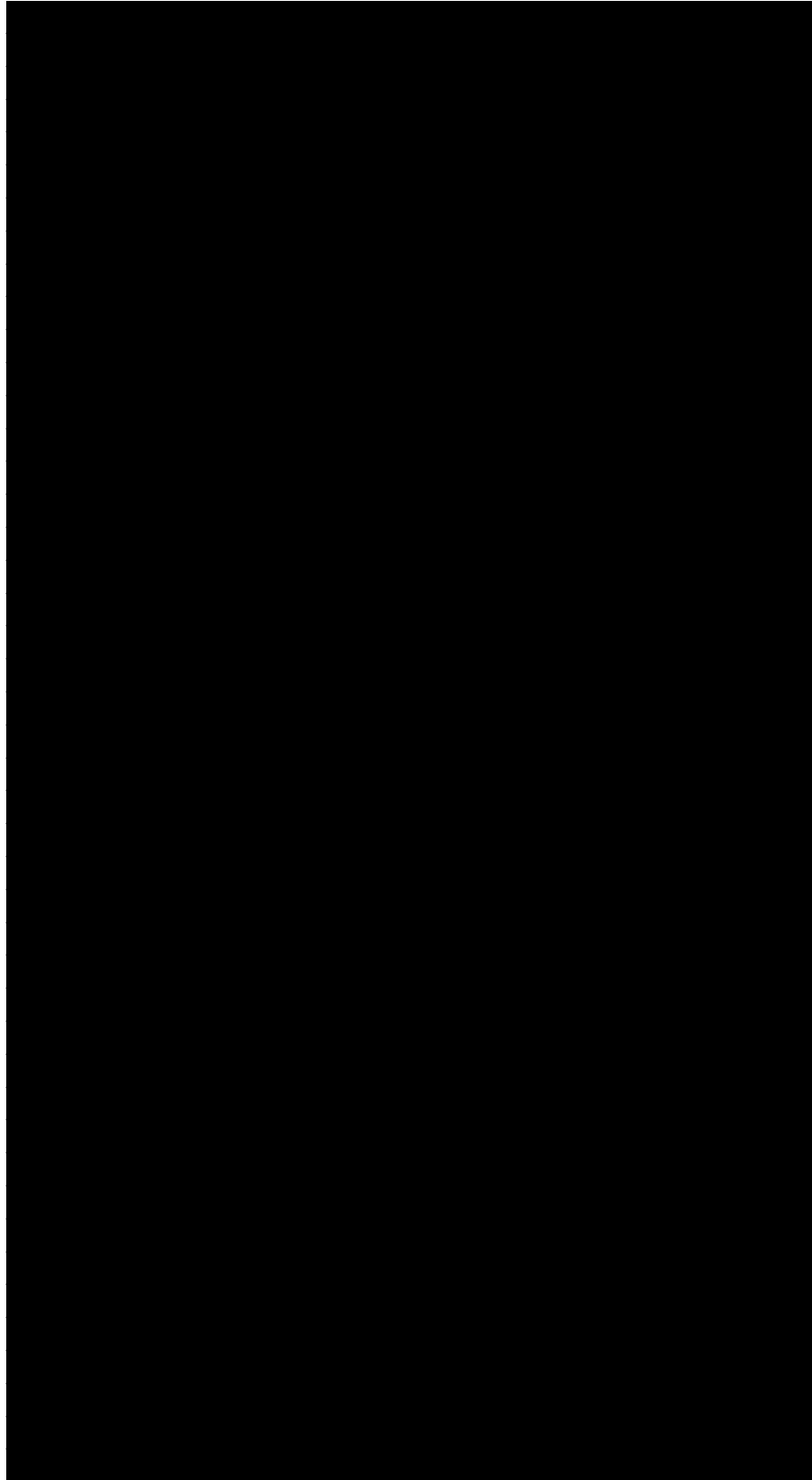




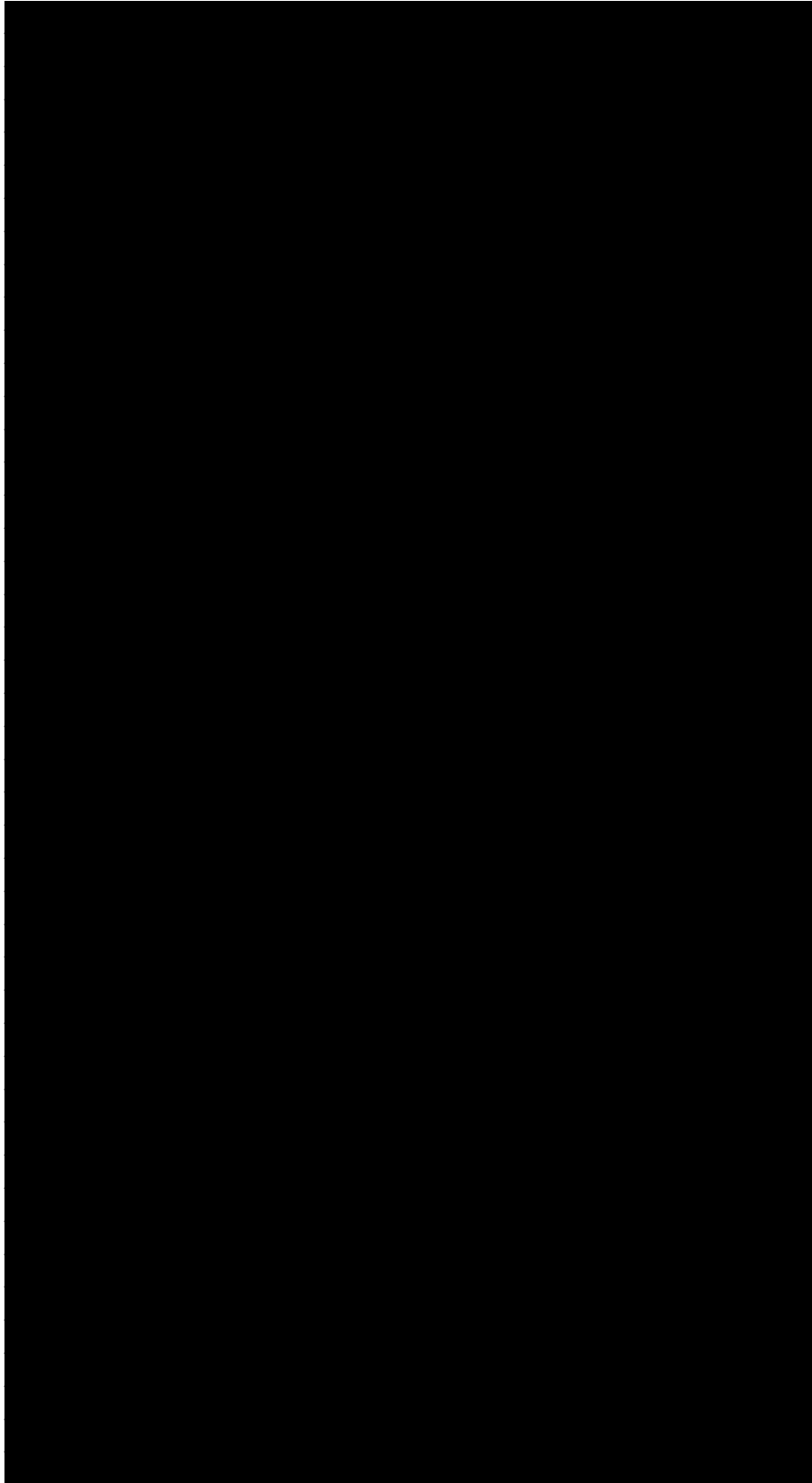
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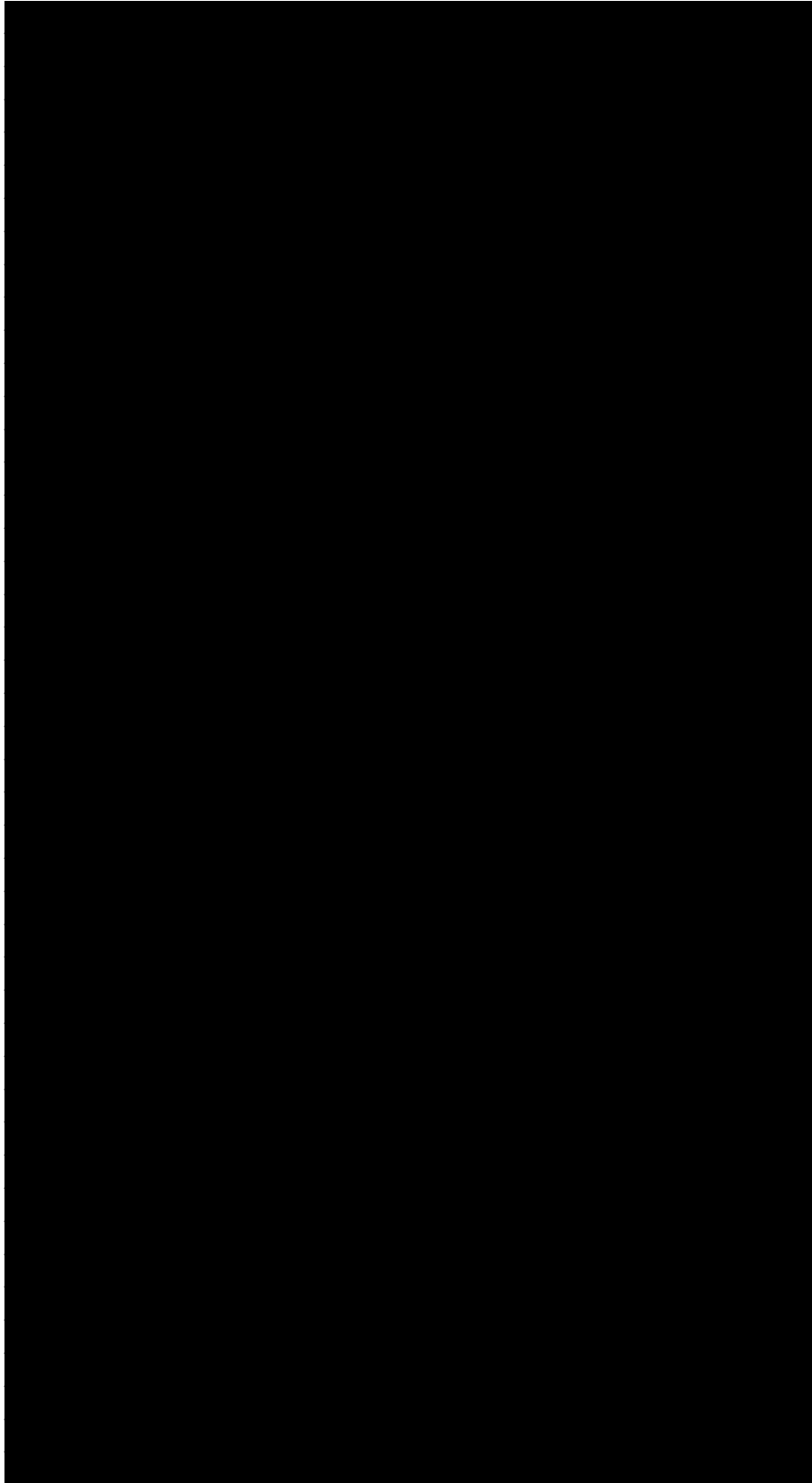
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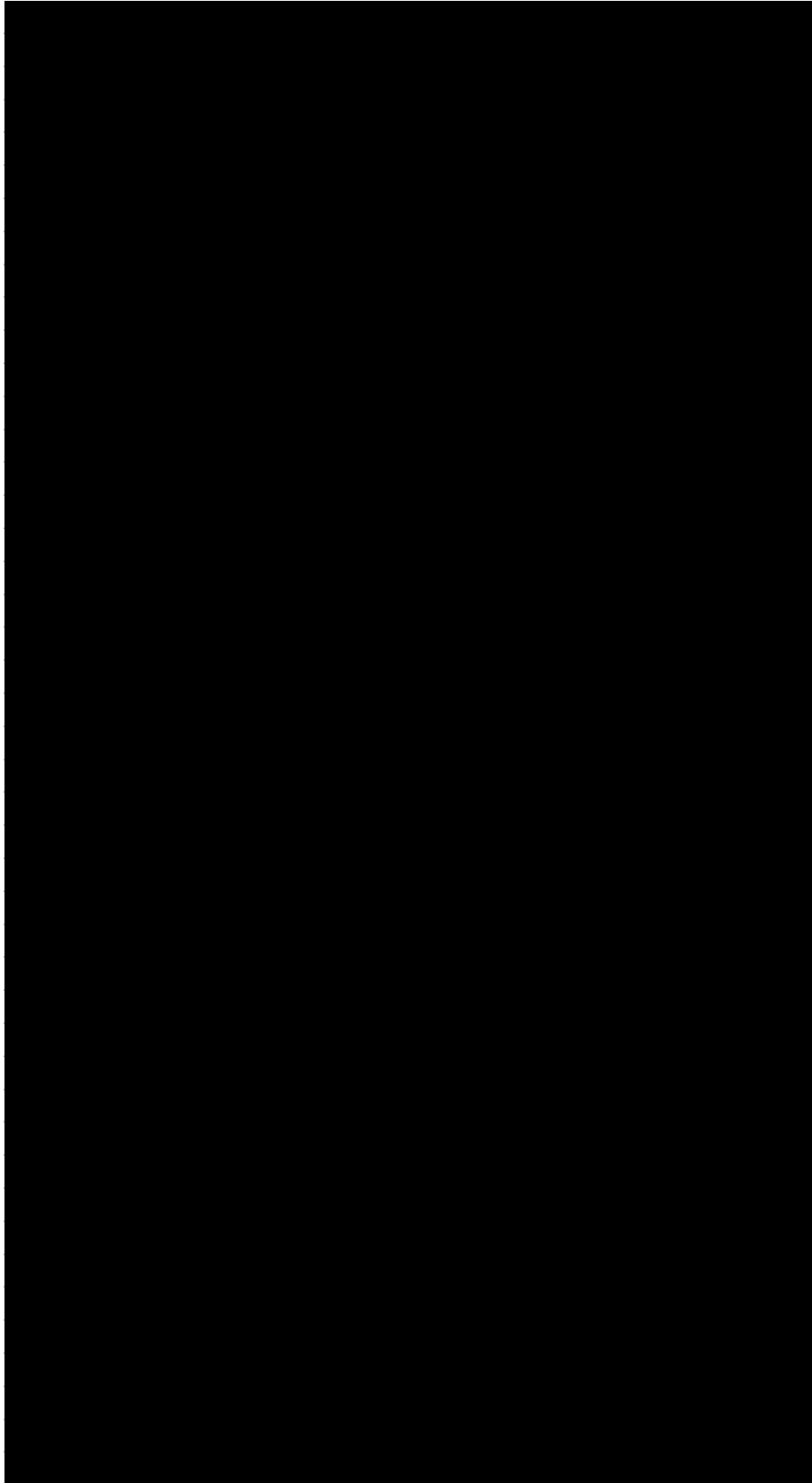
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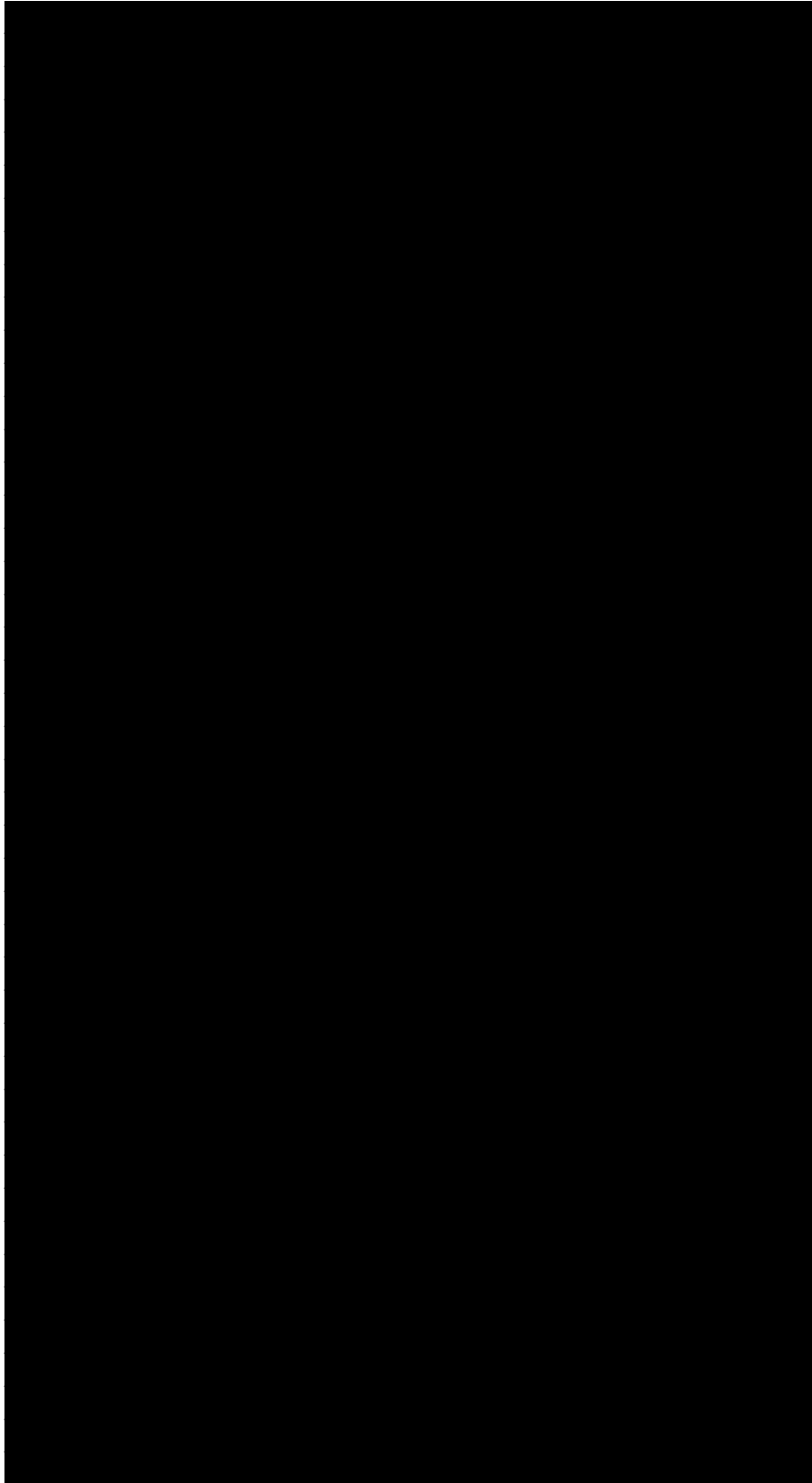
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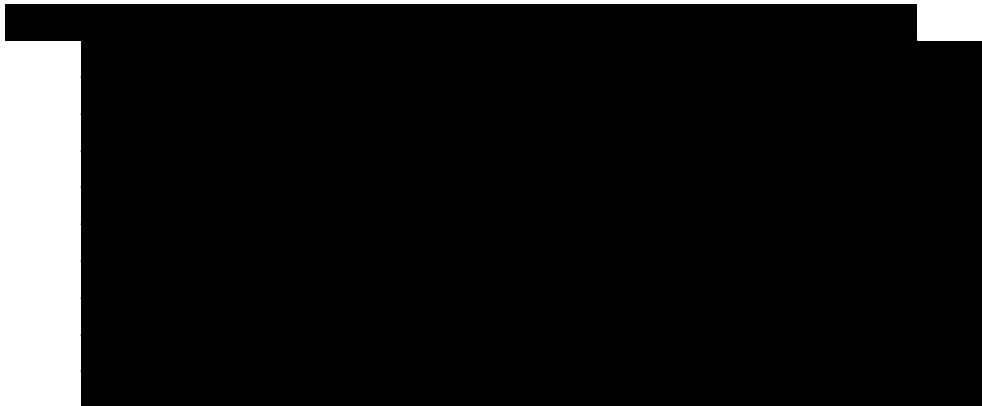
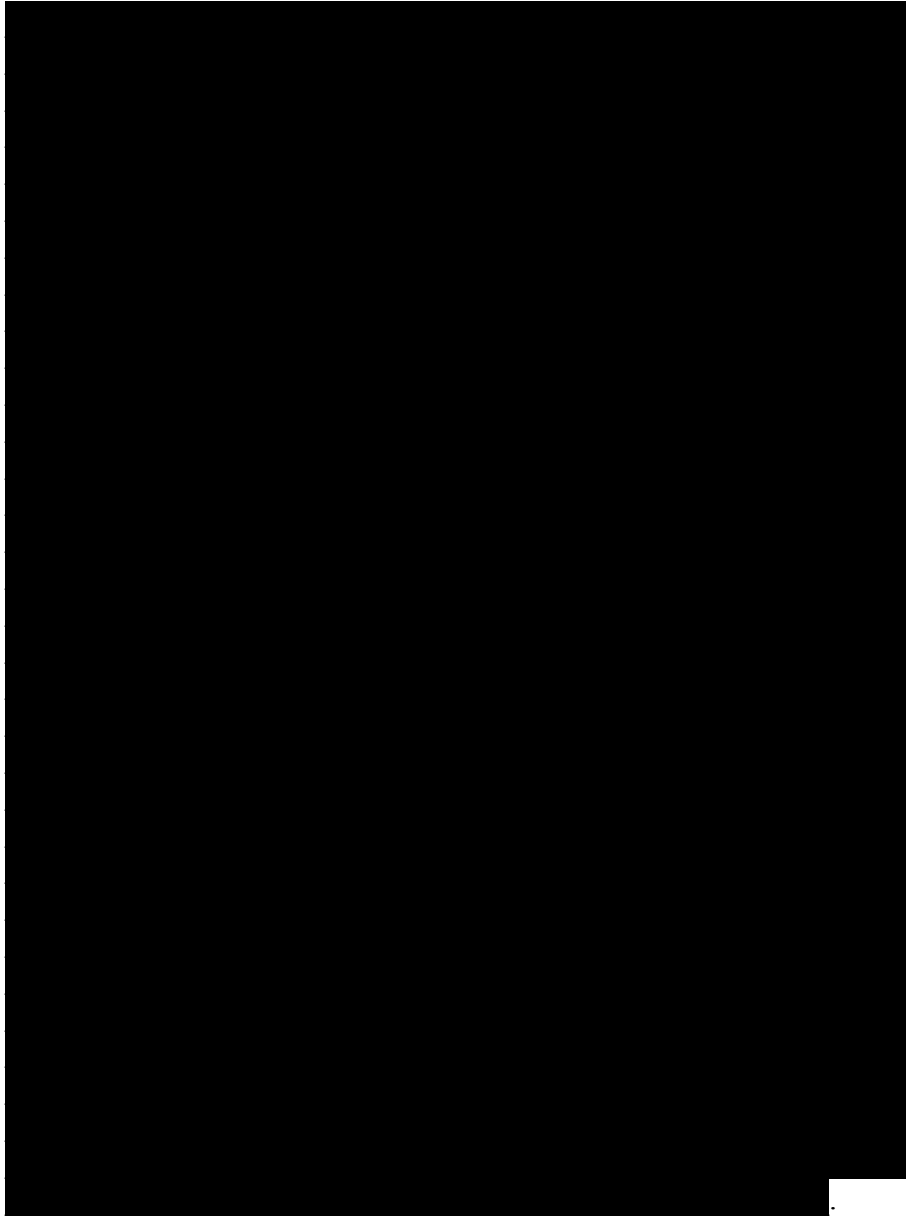
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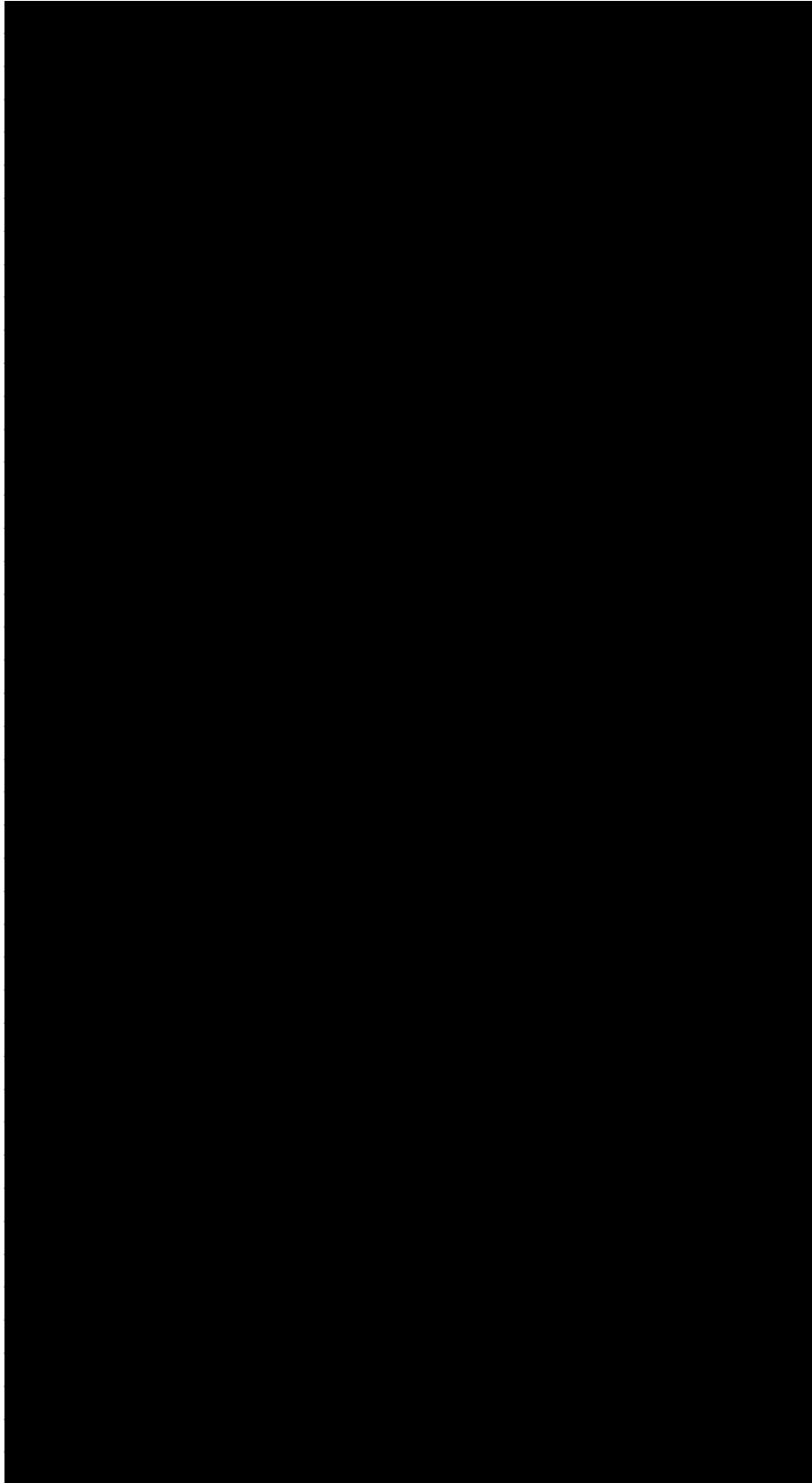
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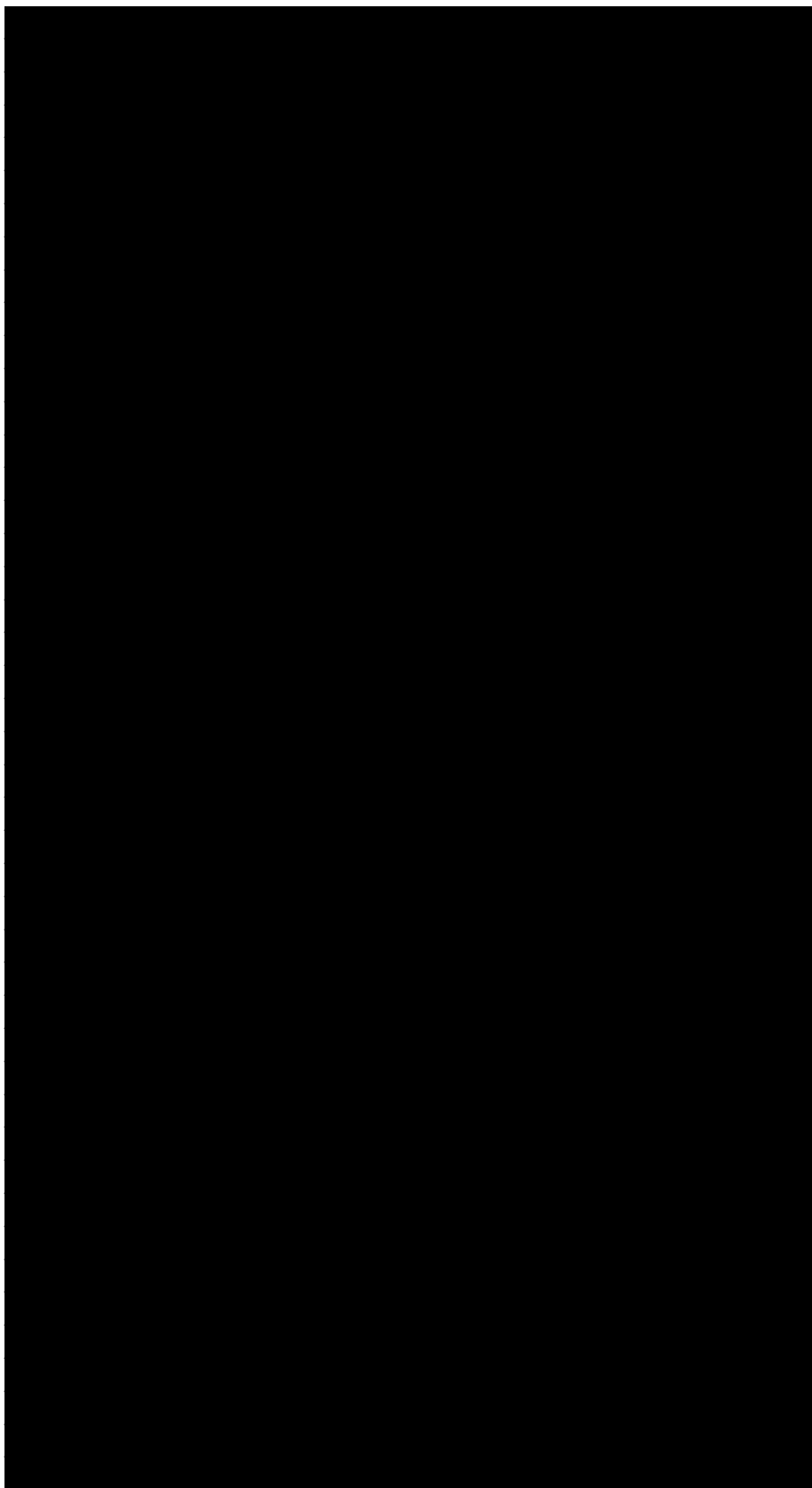
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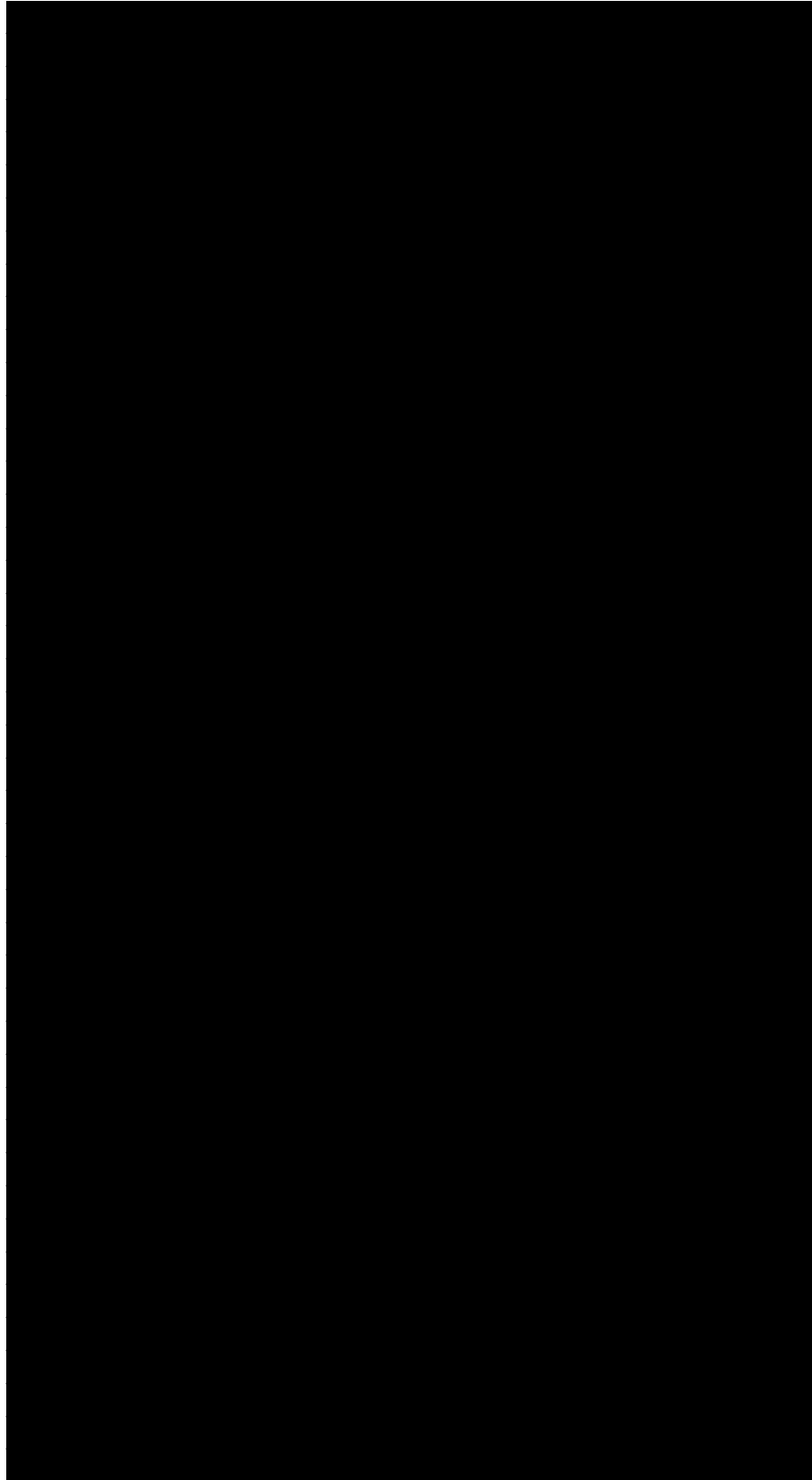
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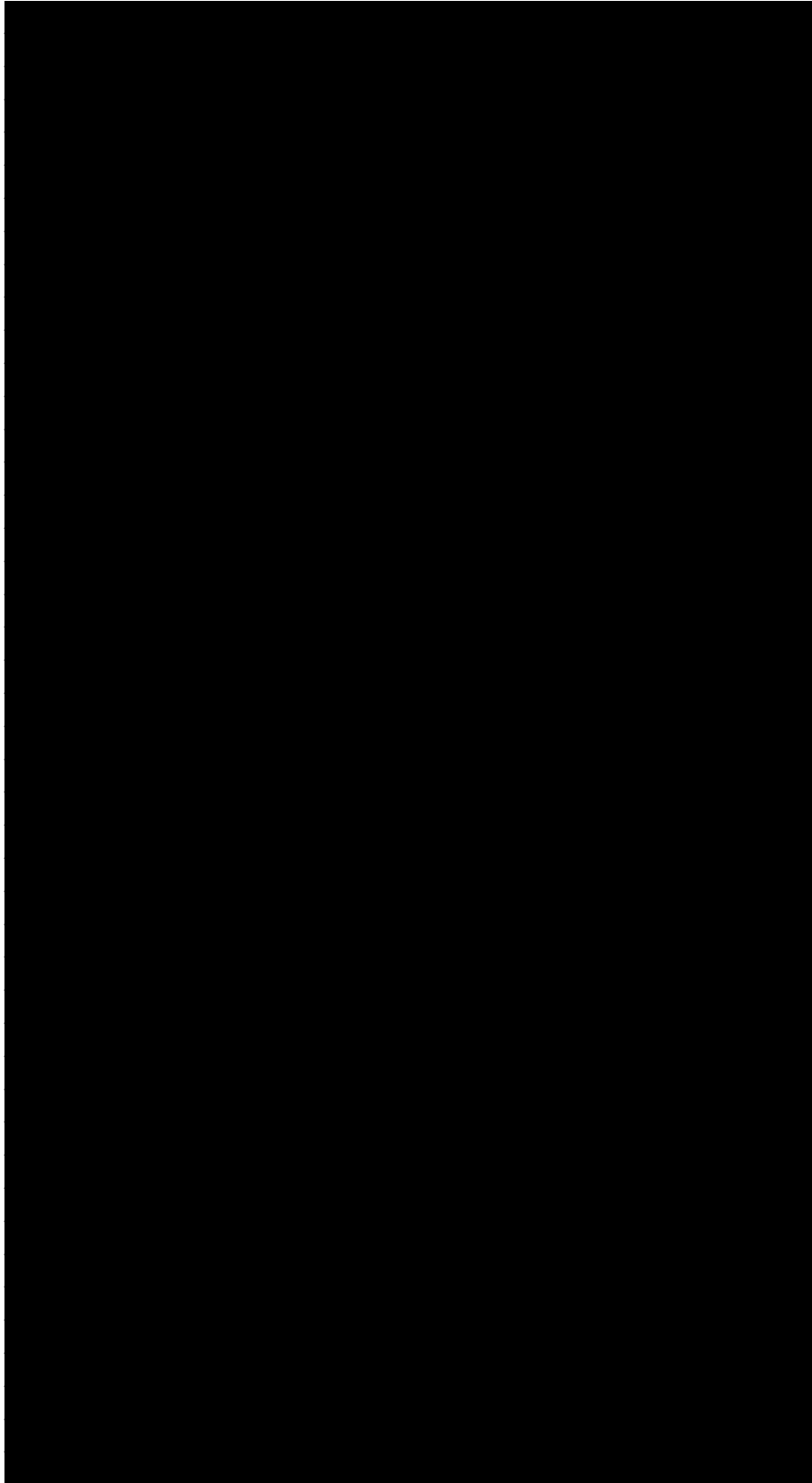
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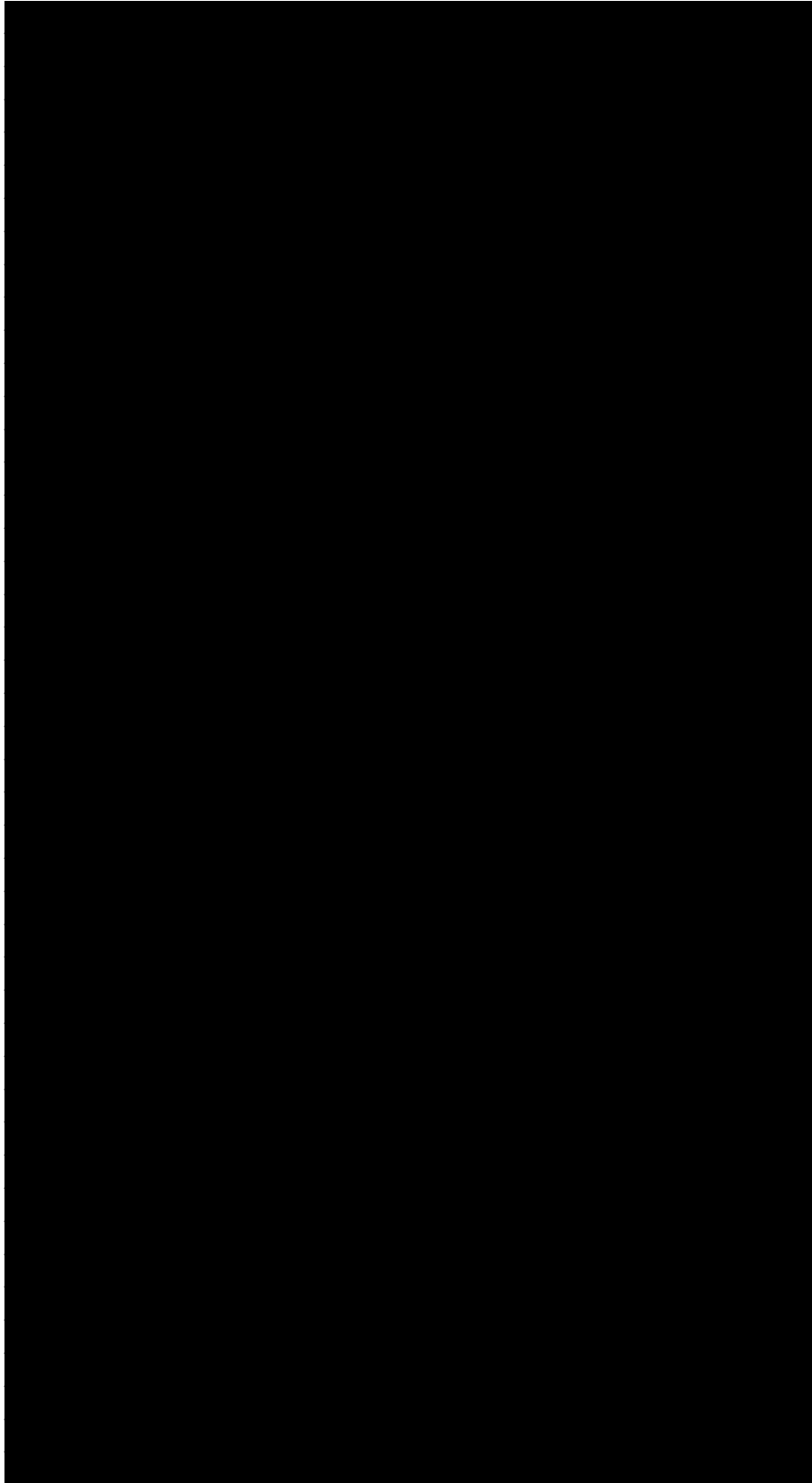
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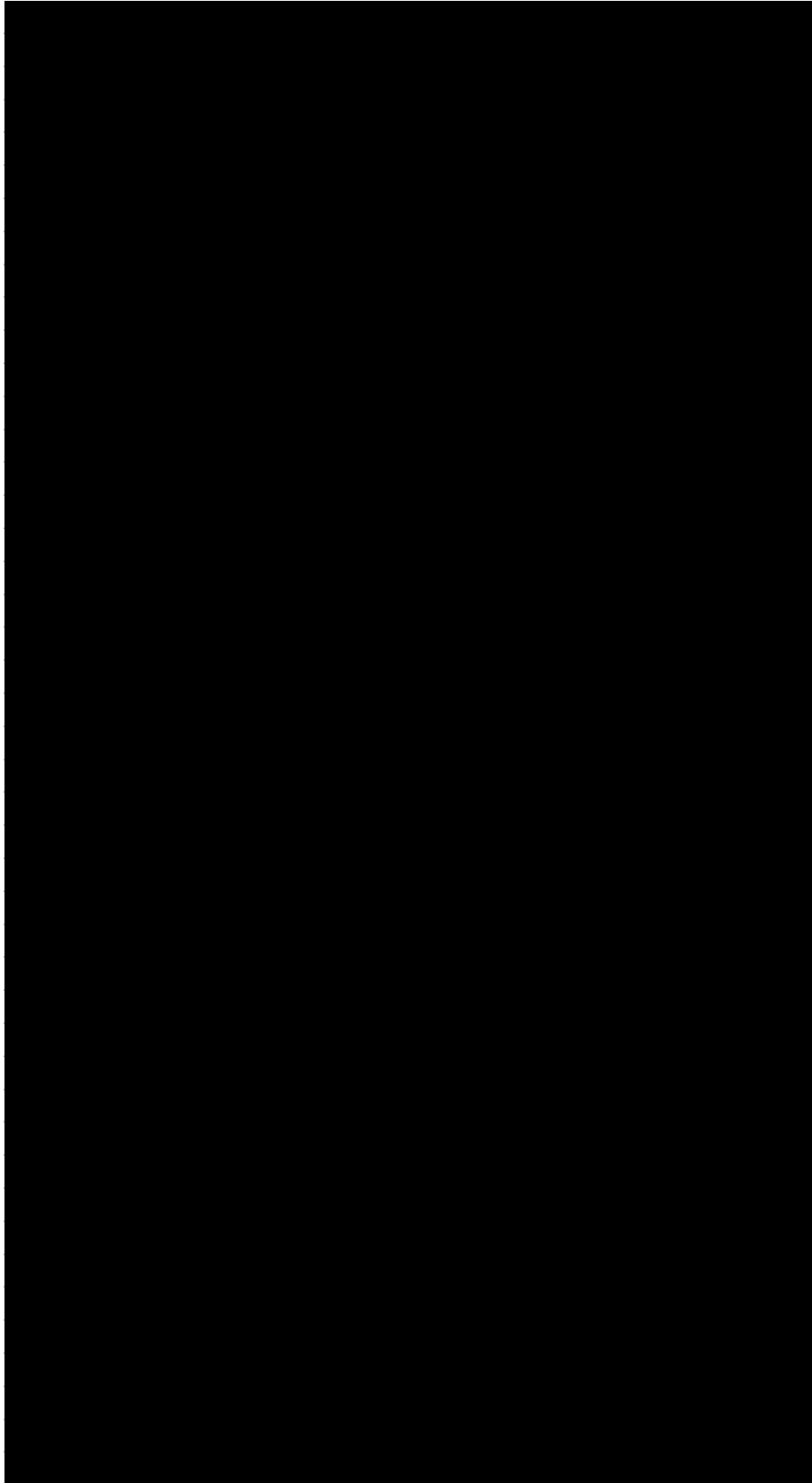
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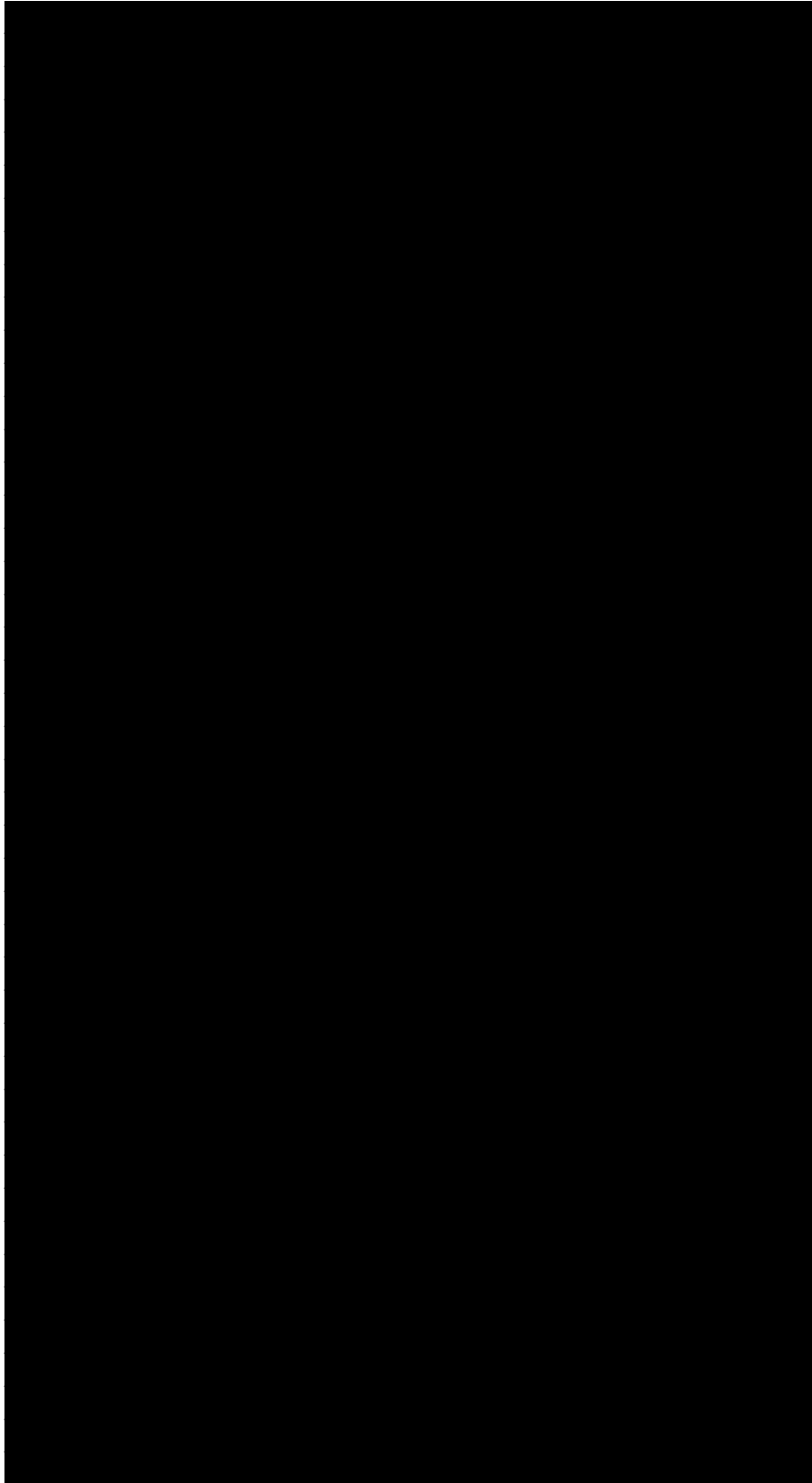
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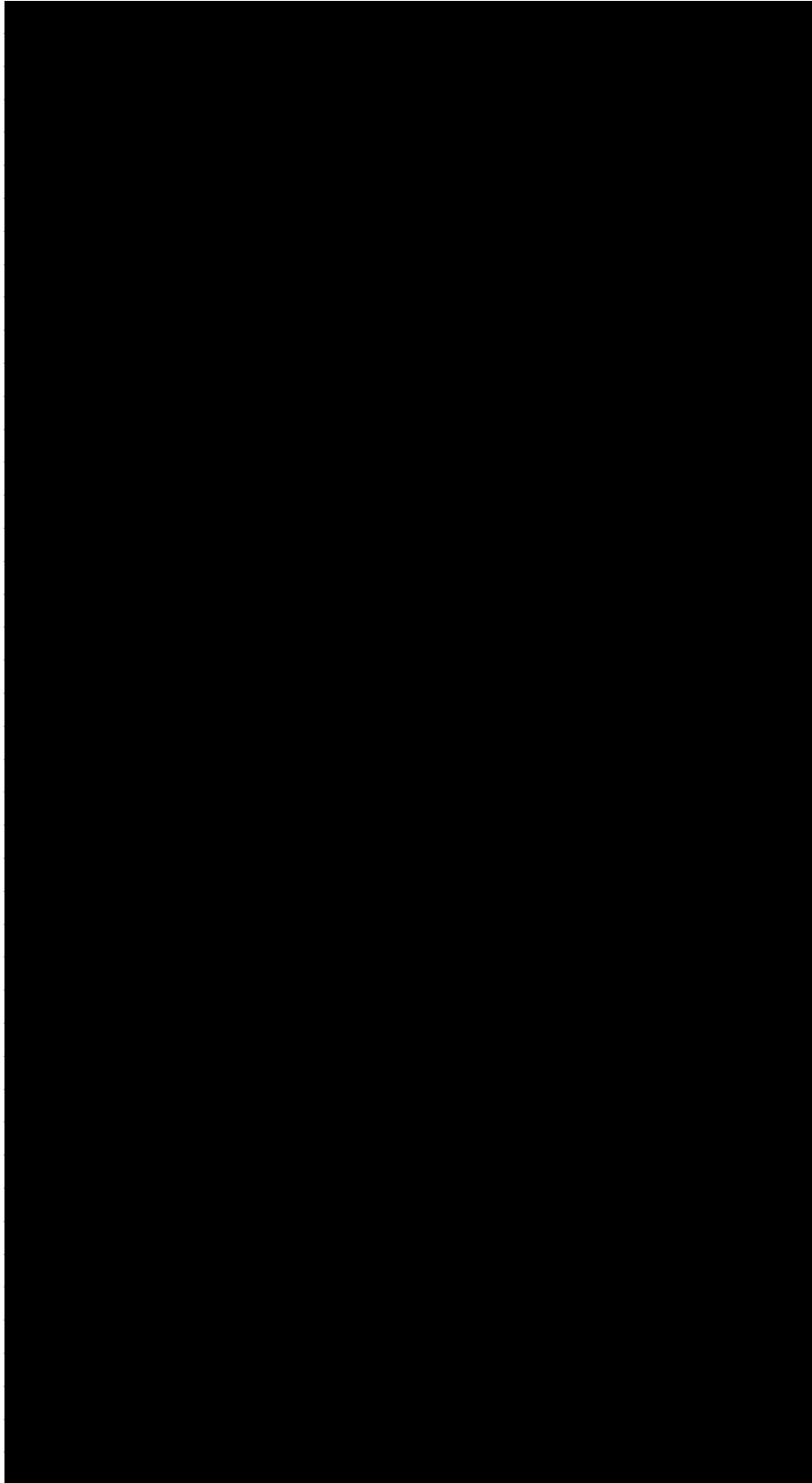
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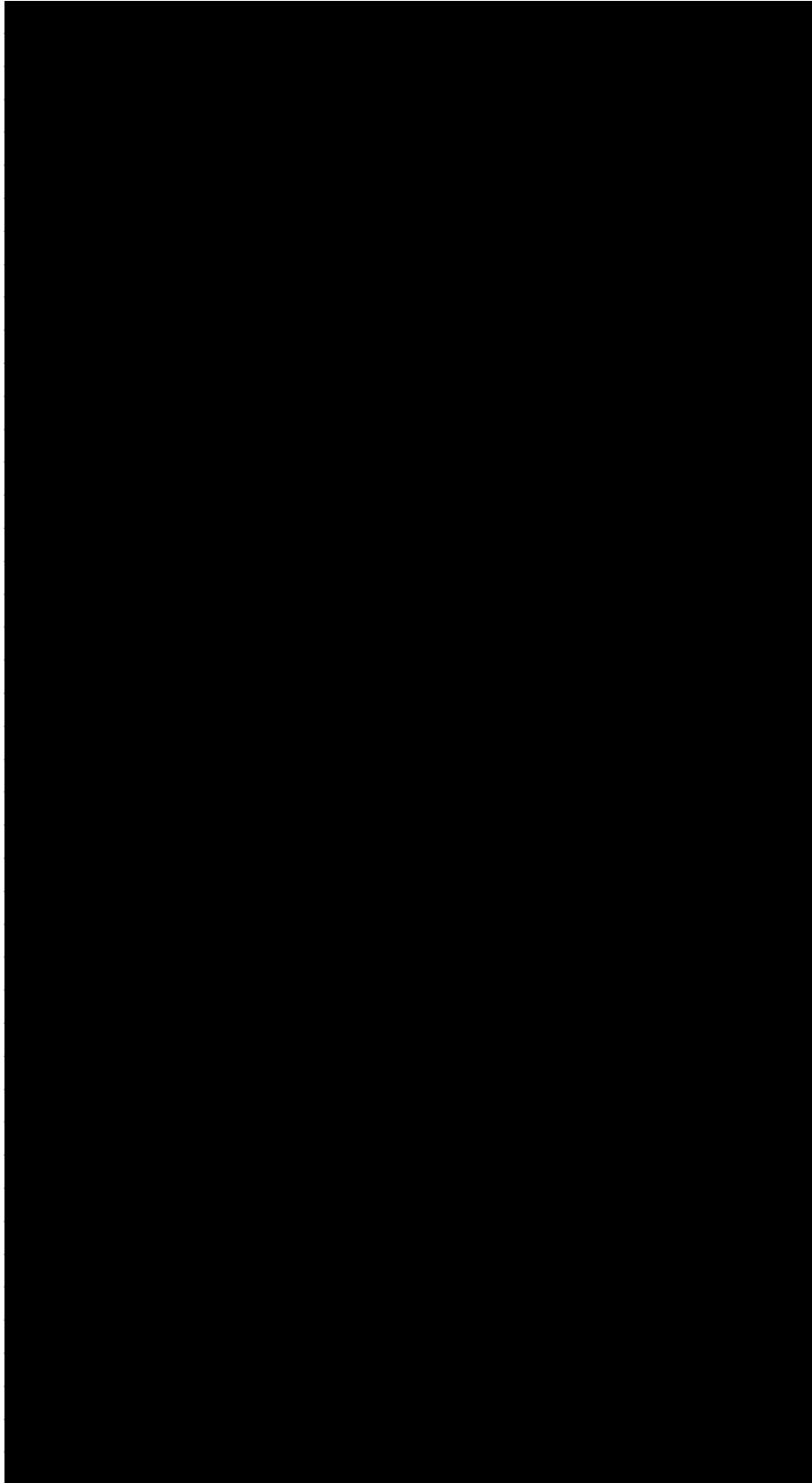
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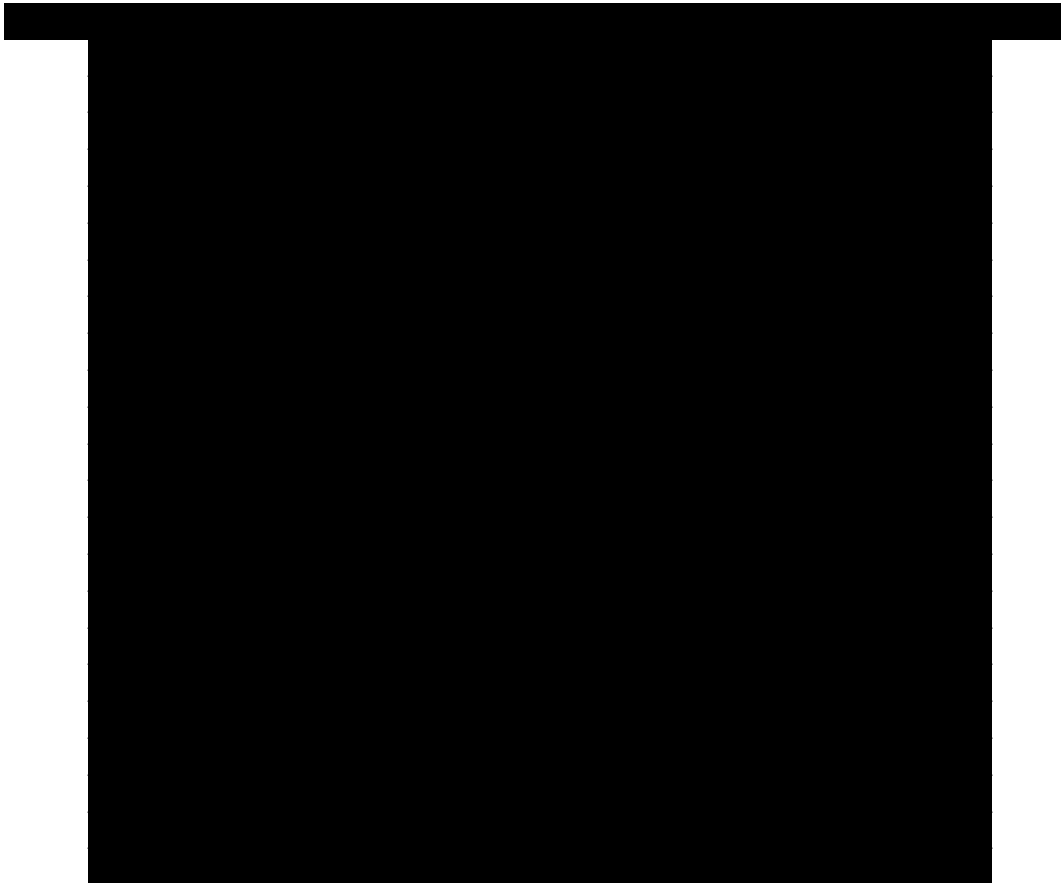
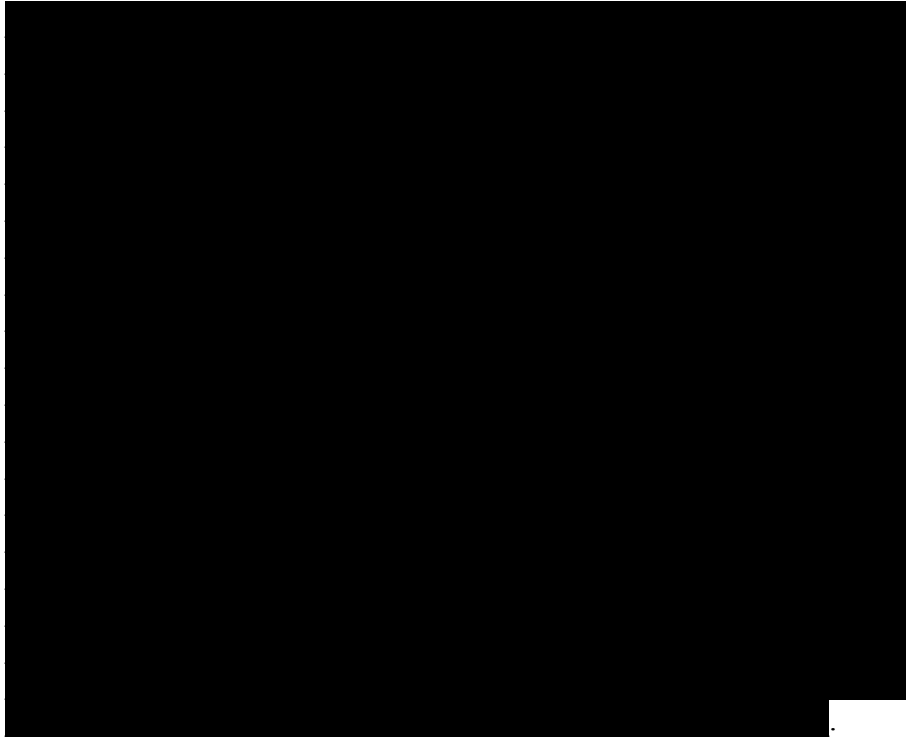
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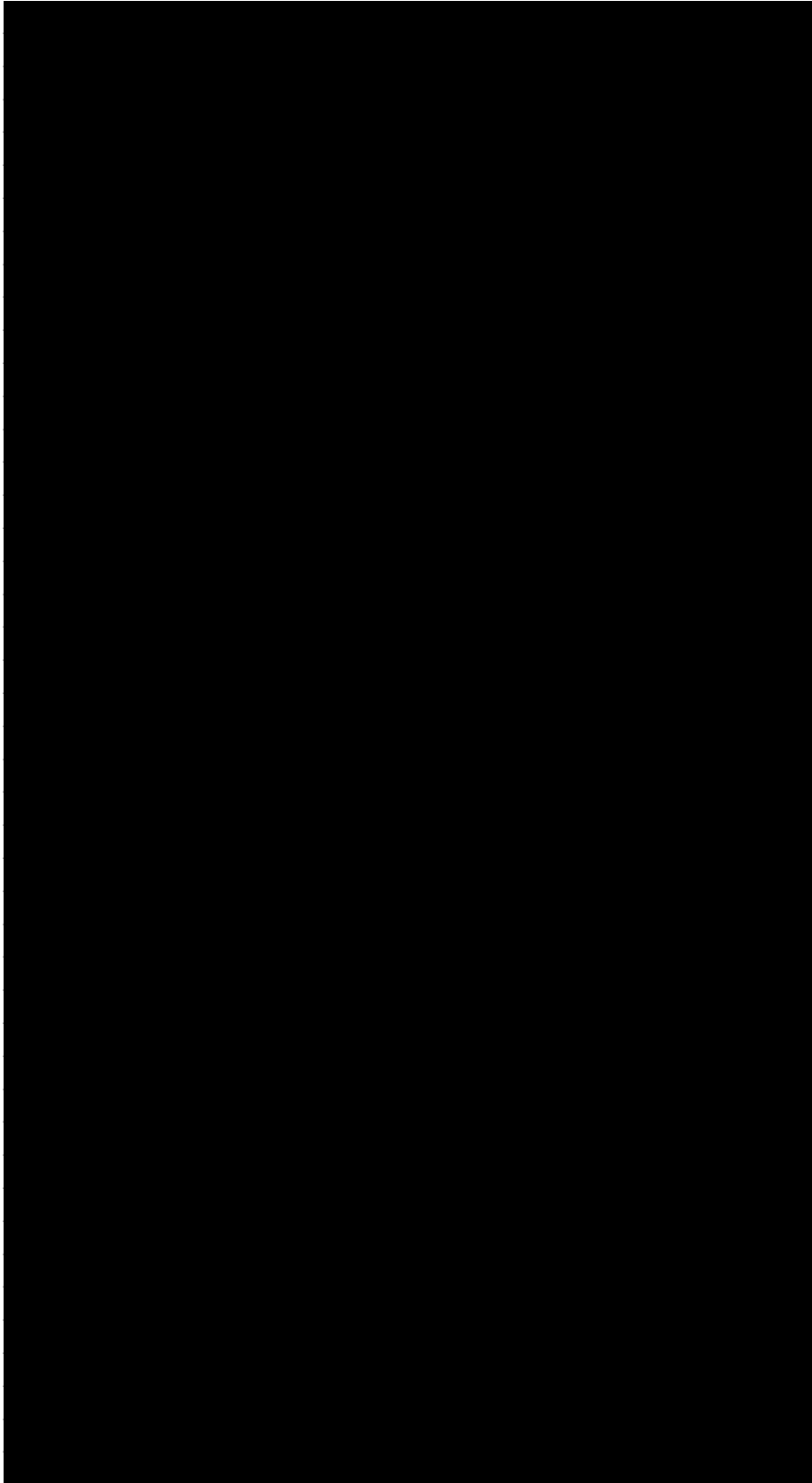
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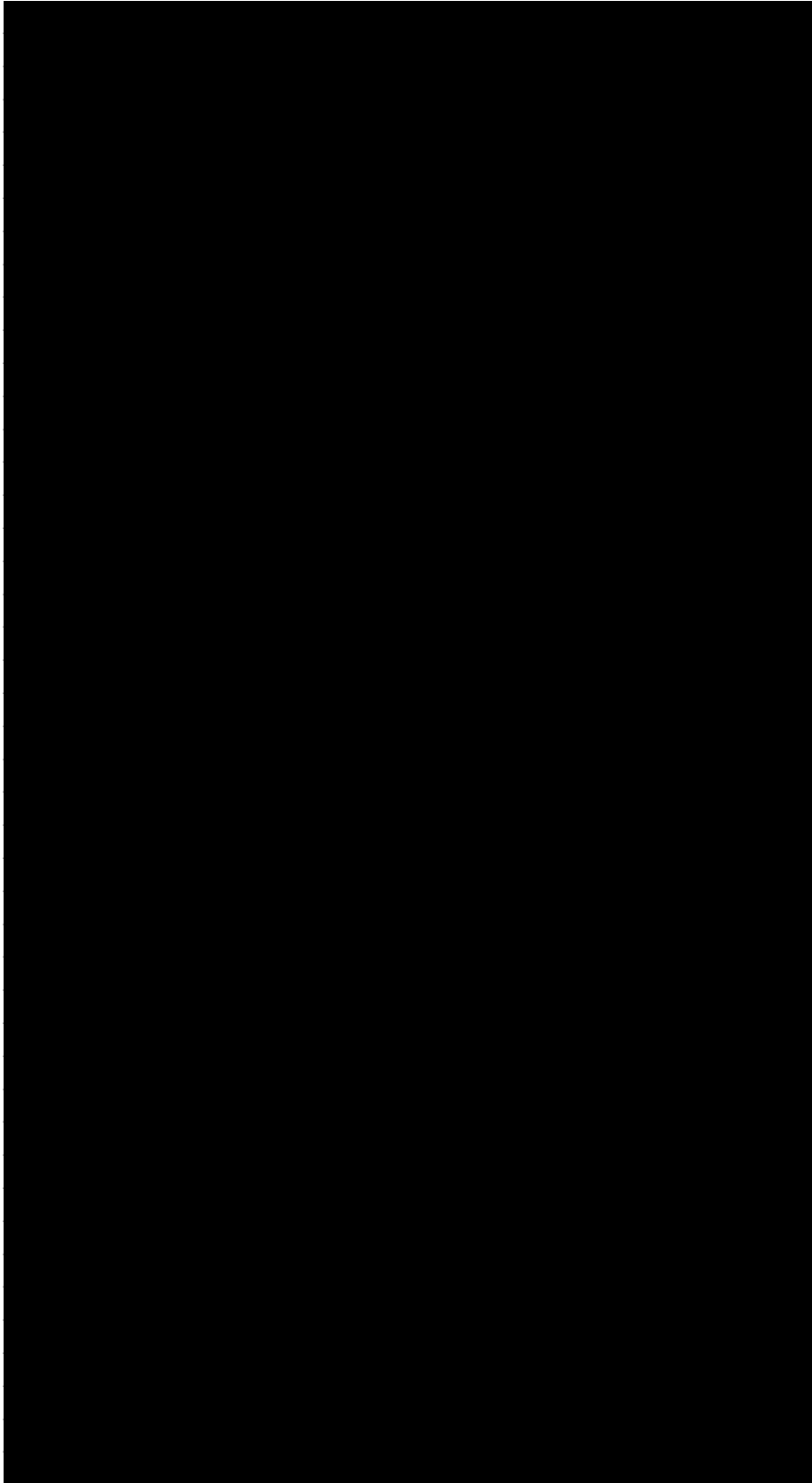
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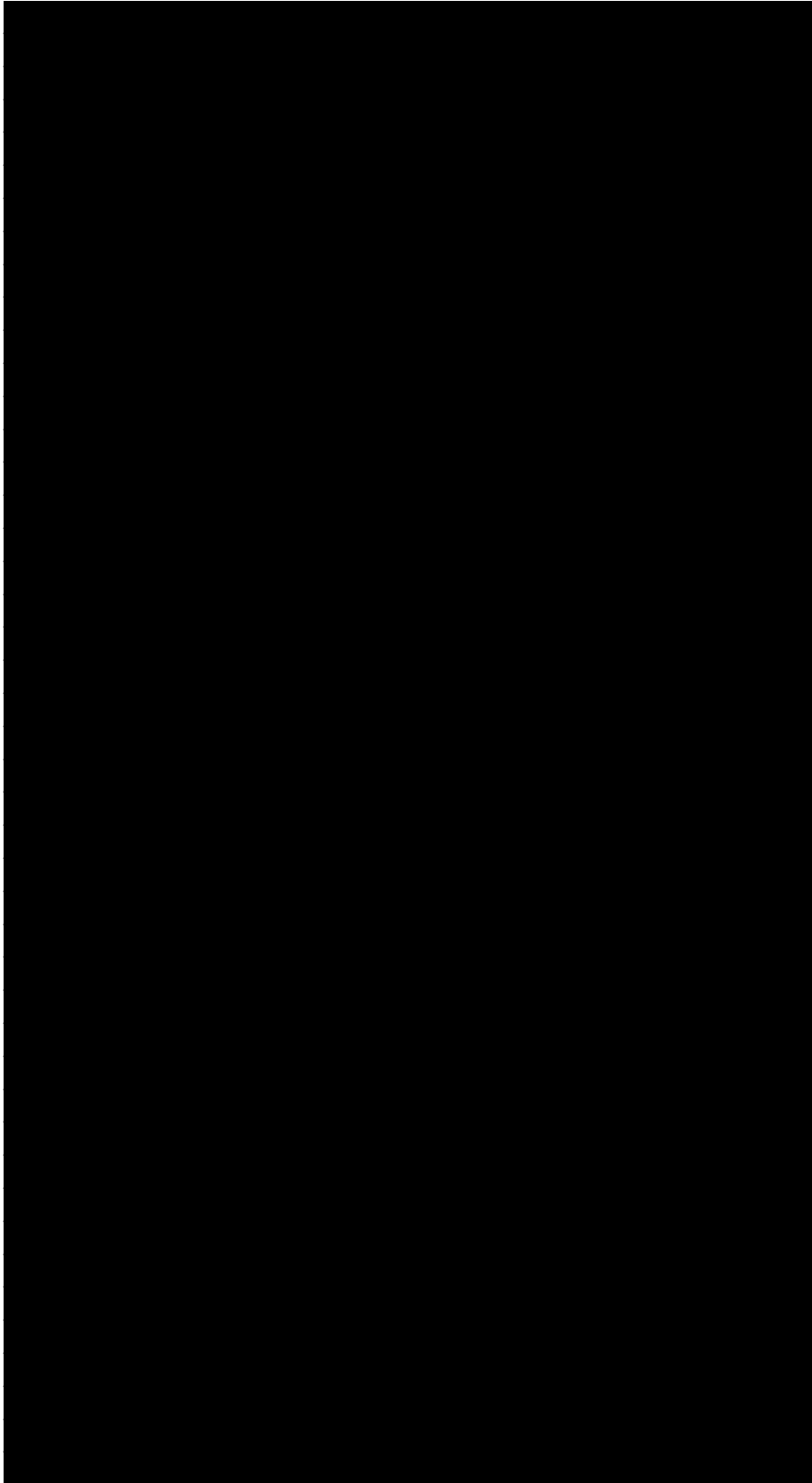
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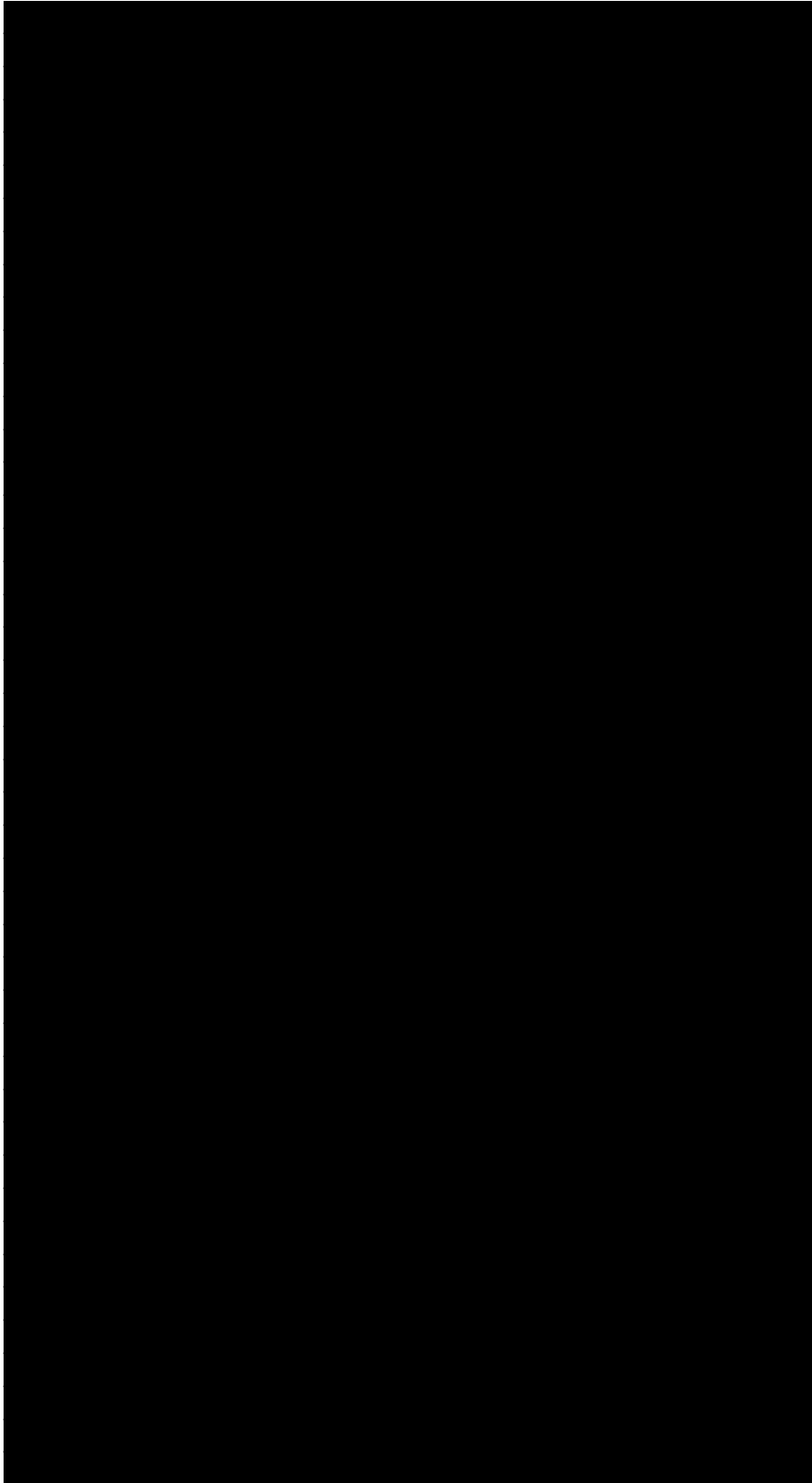
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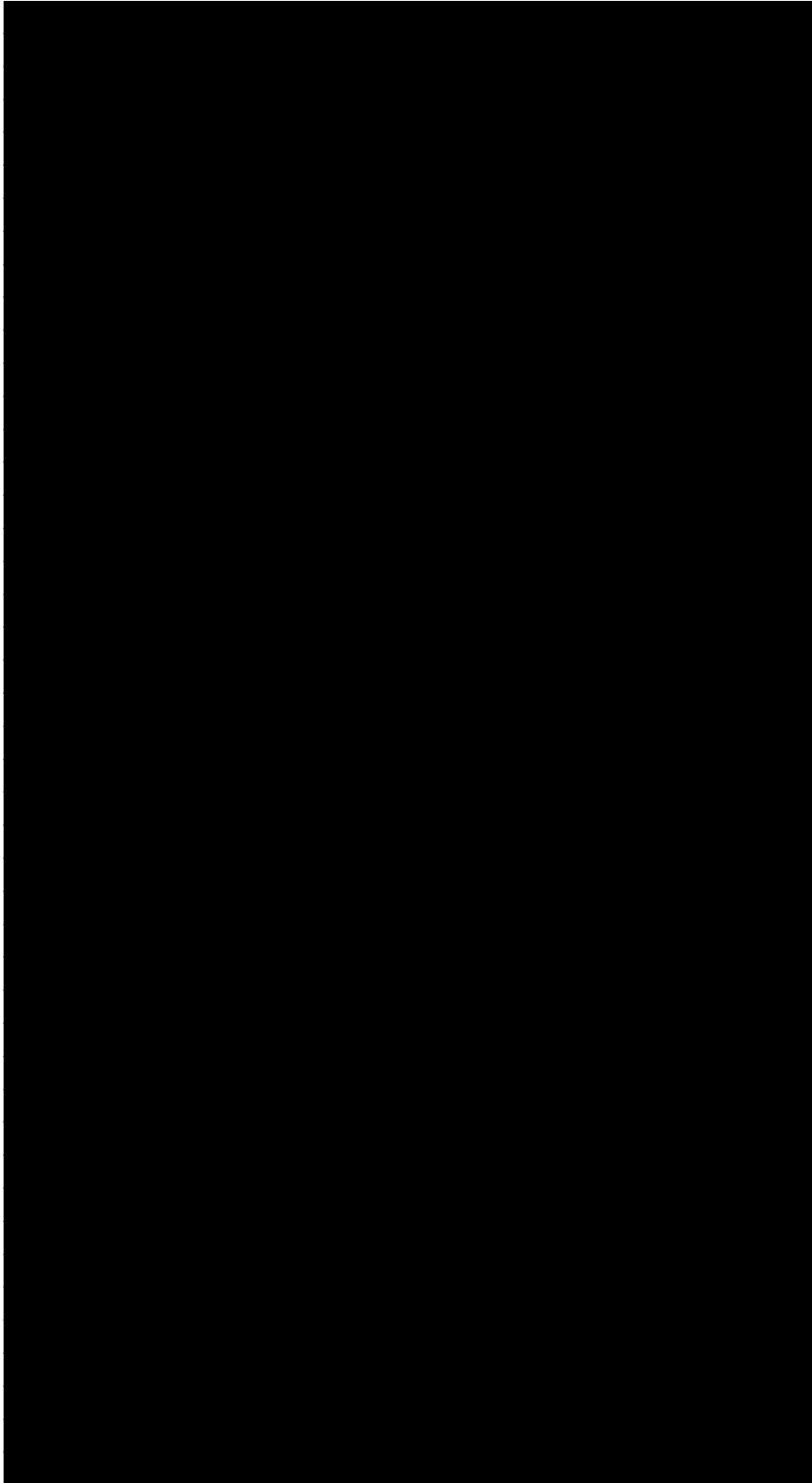
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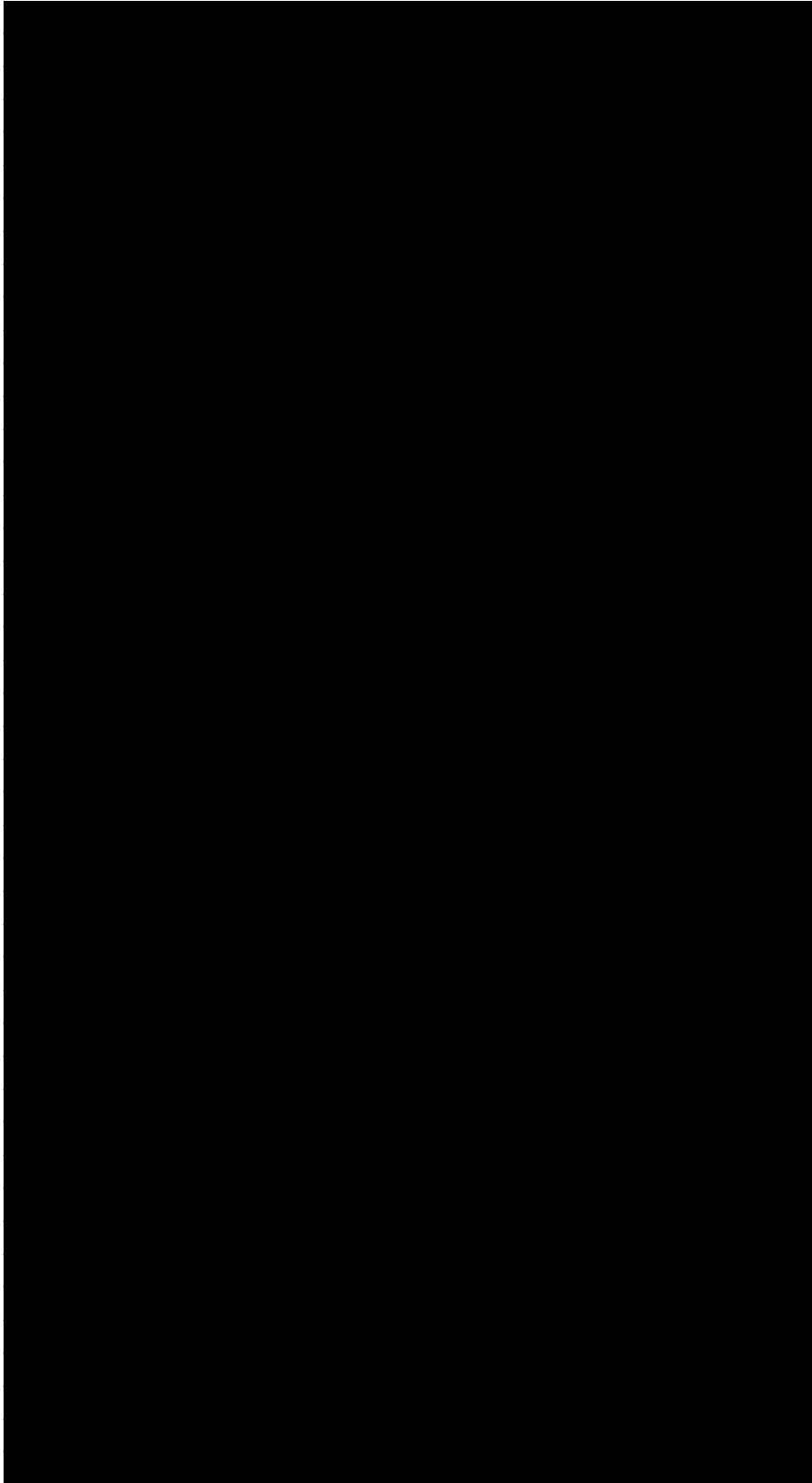
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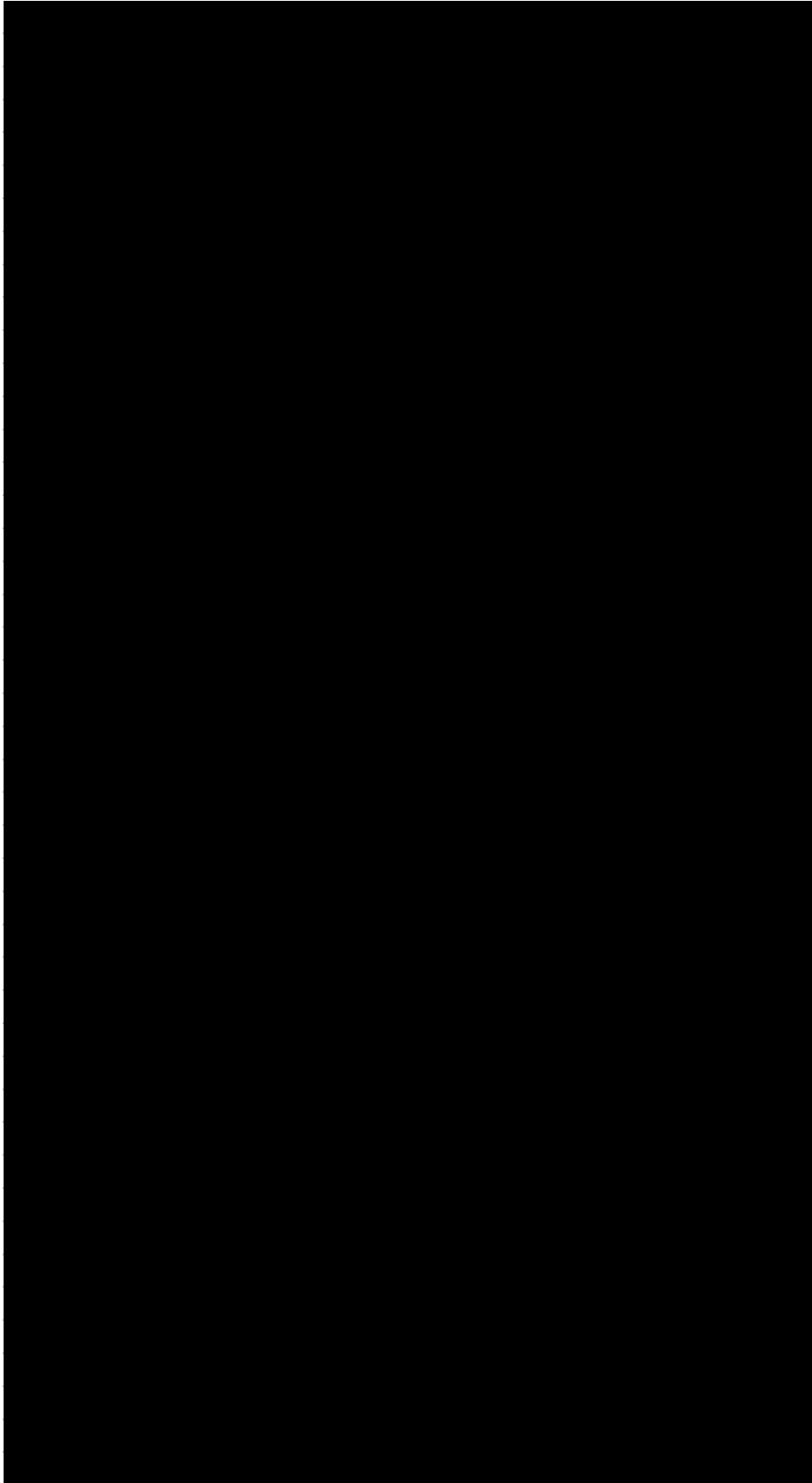


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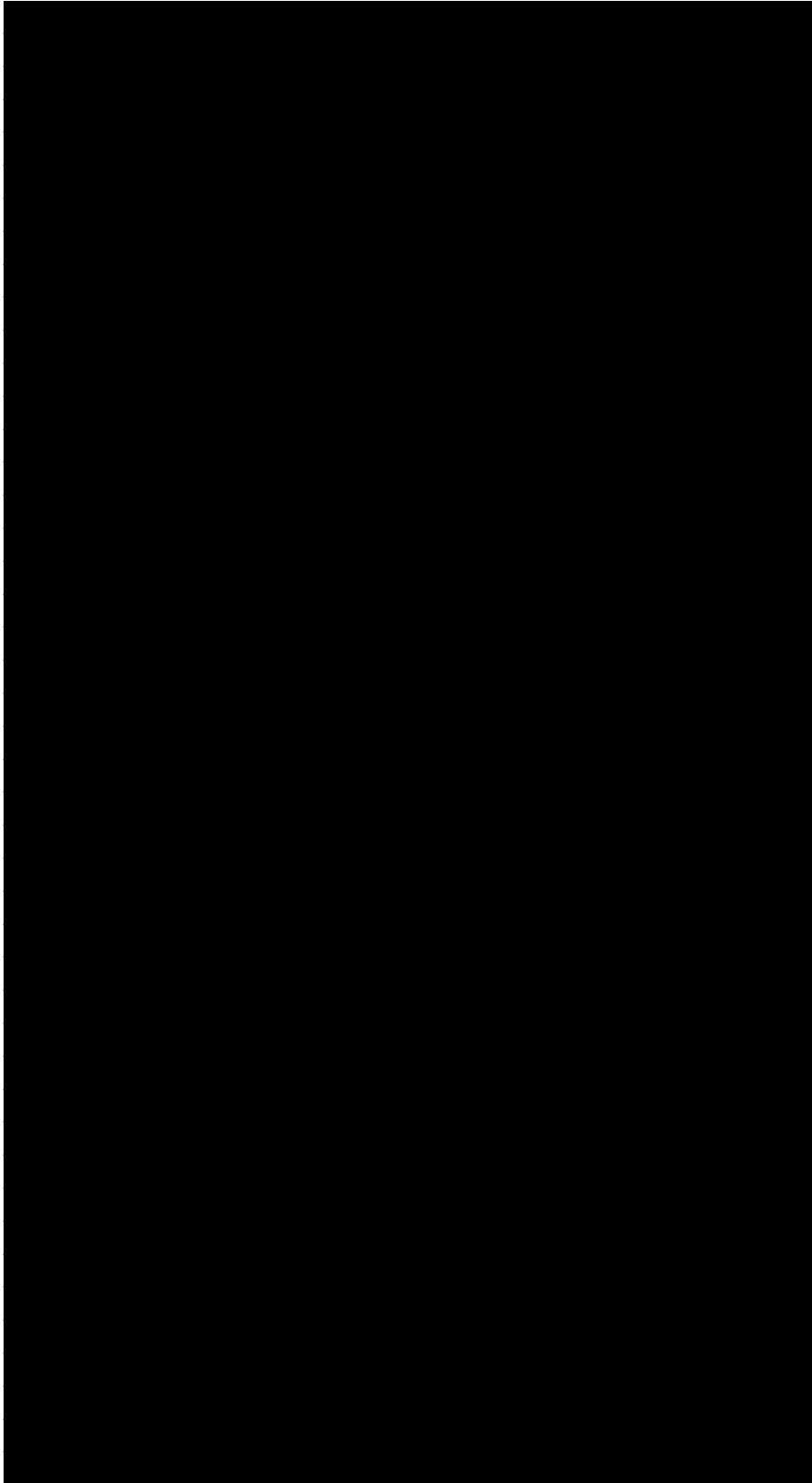


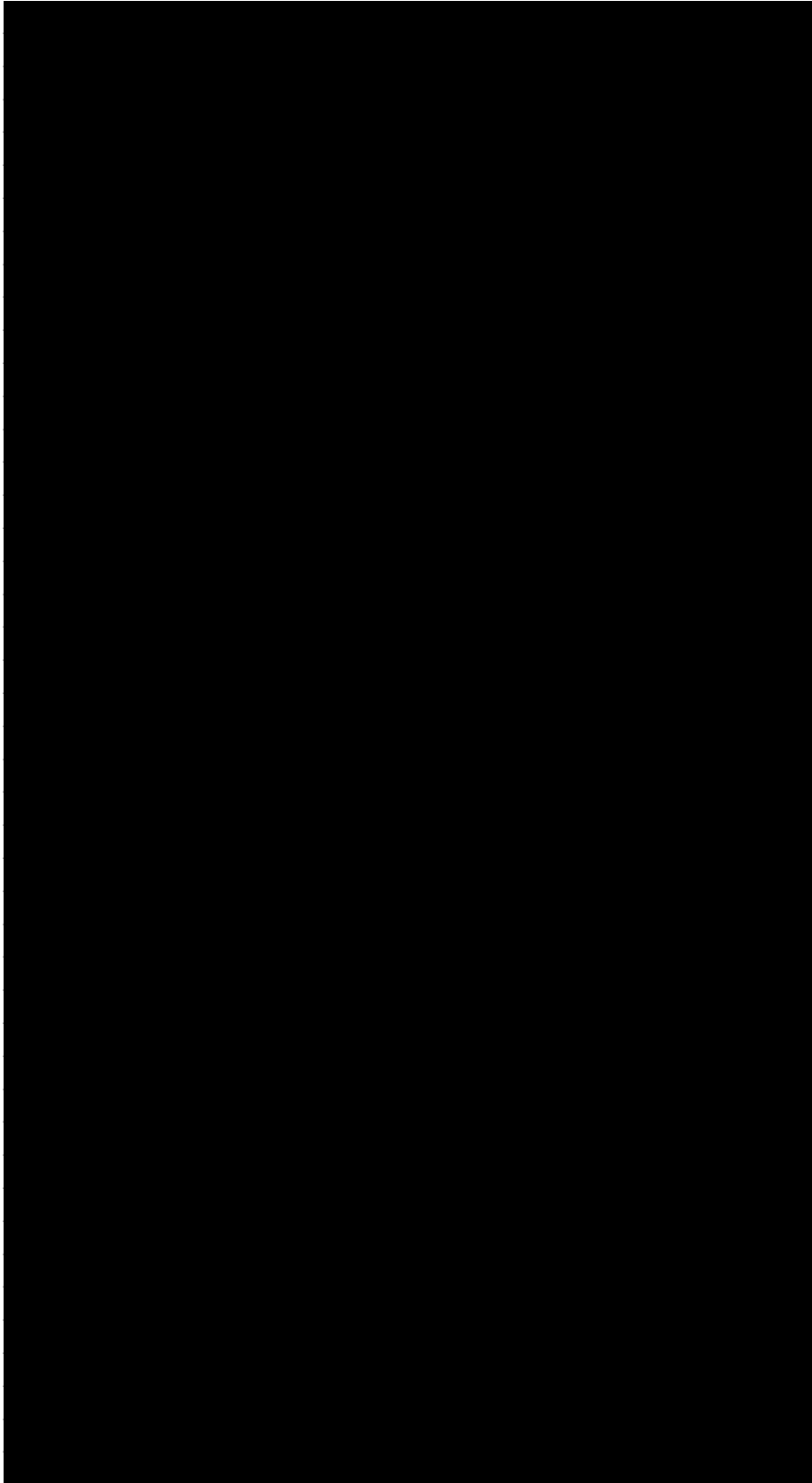
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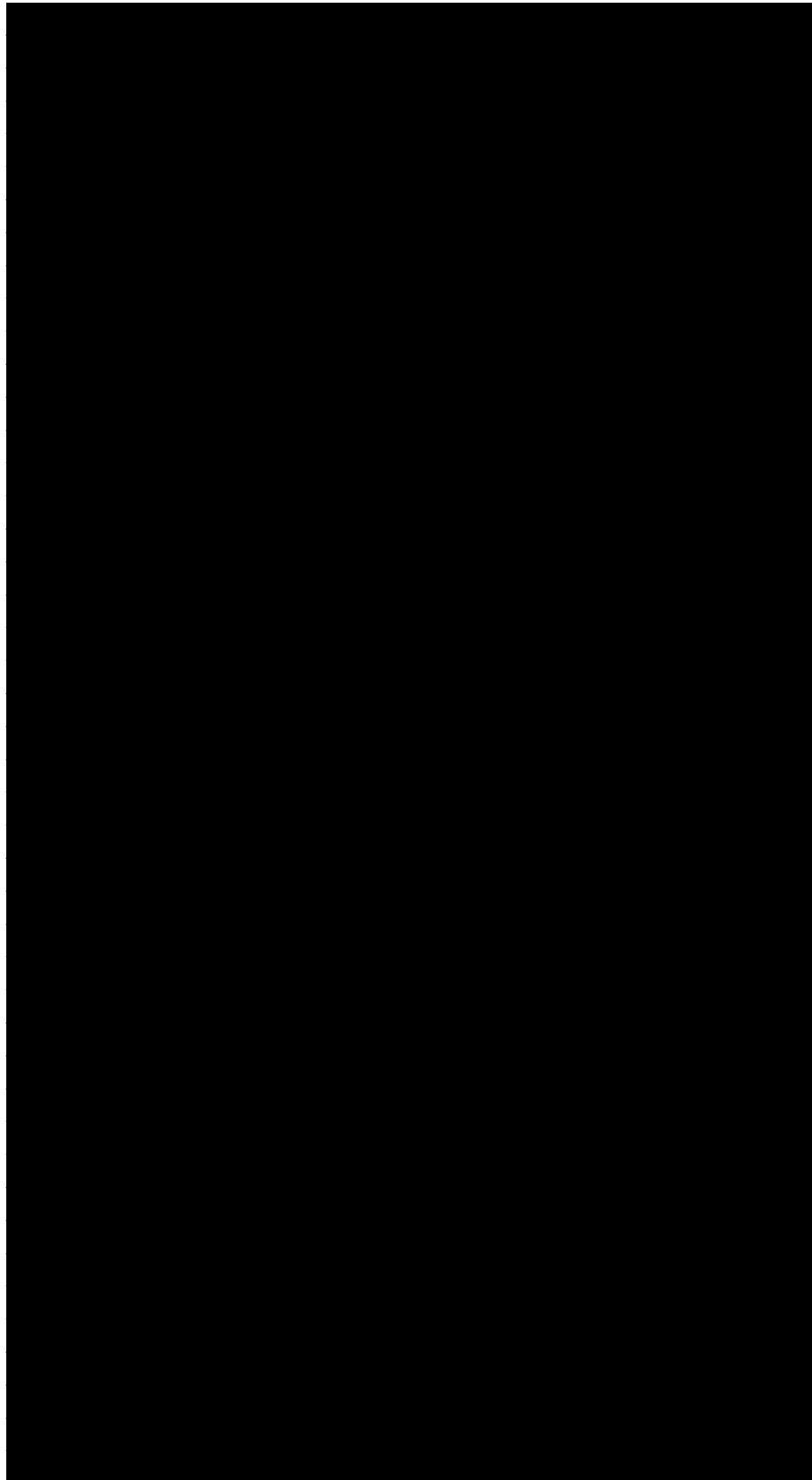


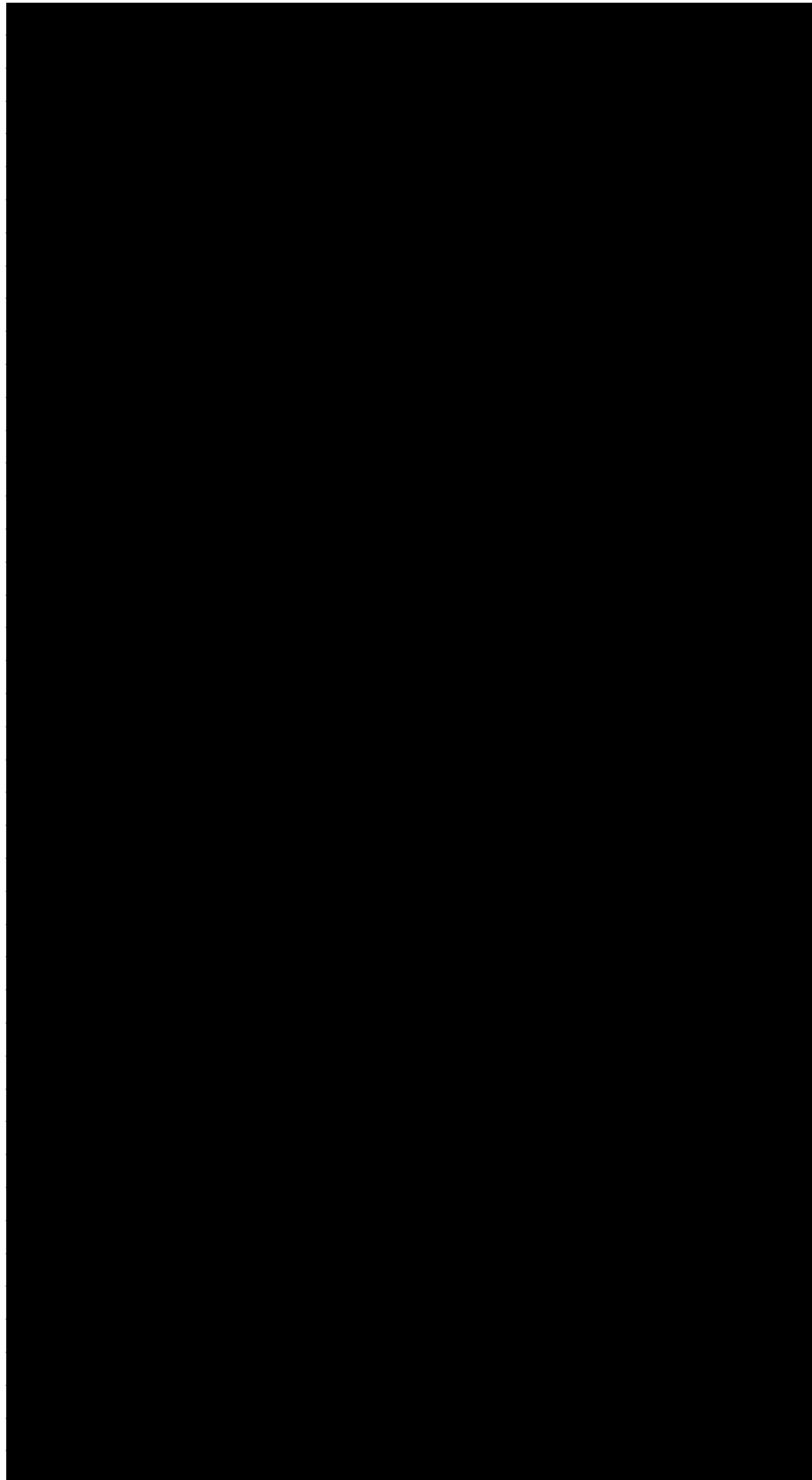


[REDACTED]

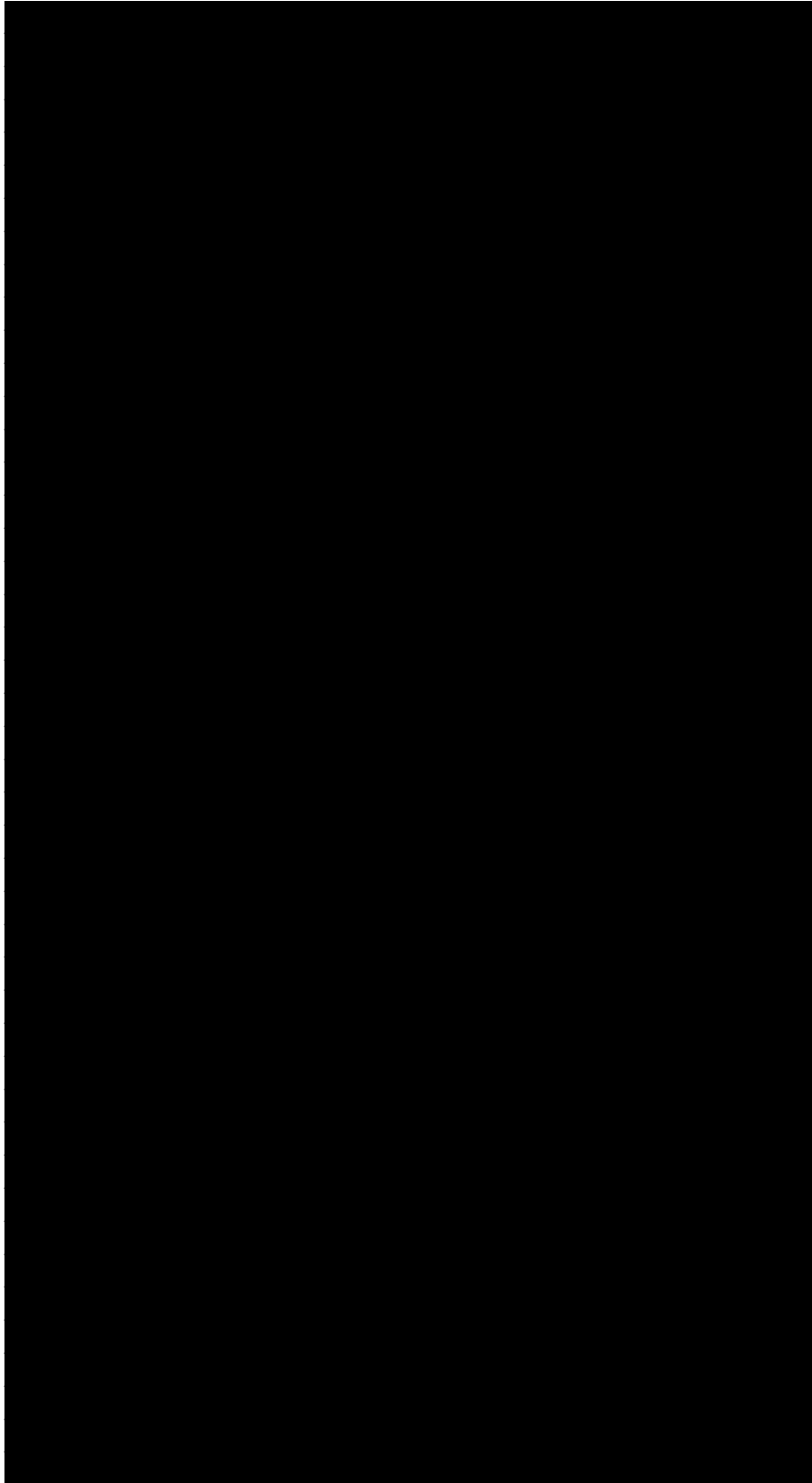
In the case of an MCO or PIHP-“Action” means--

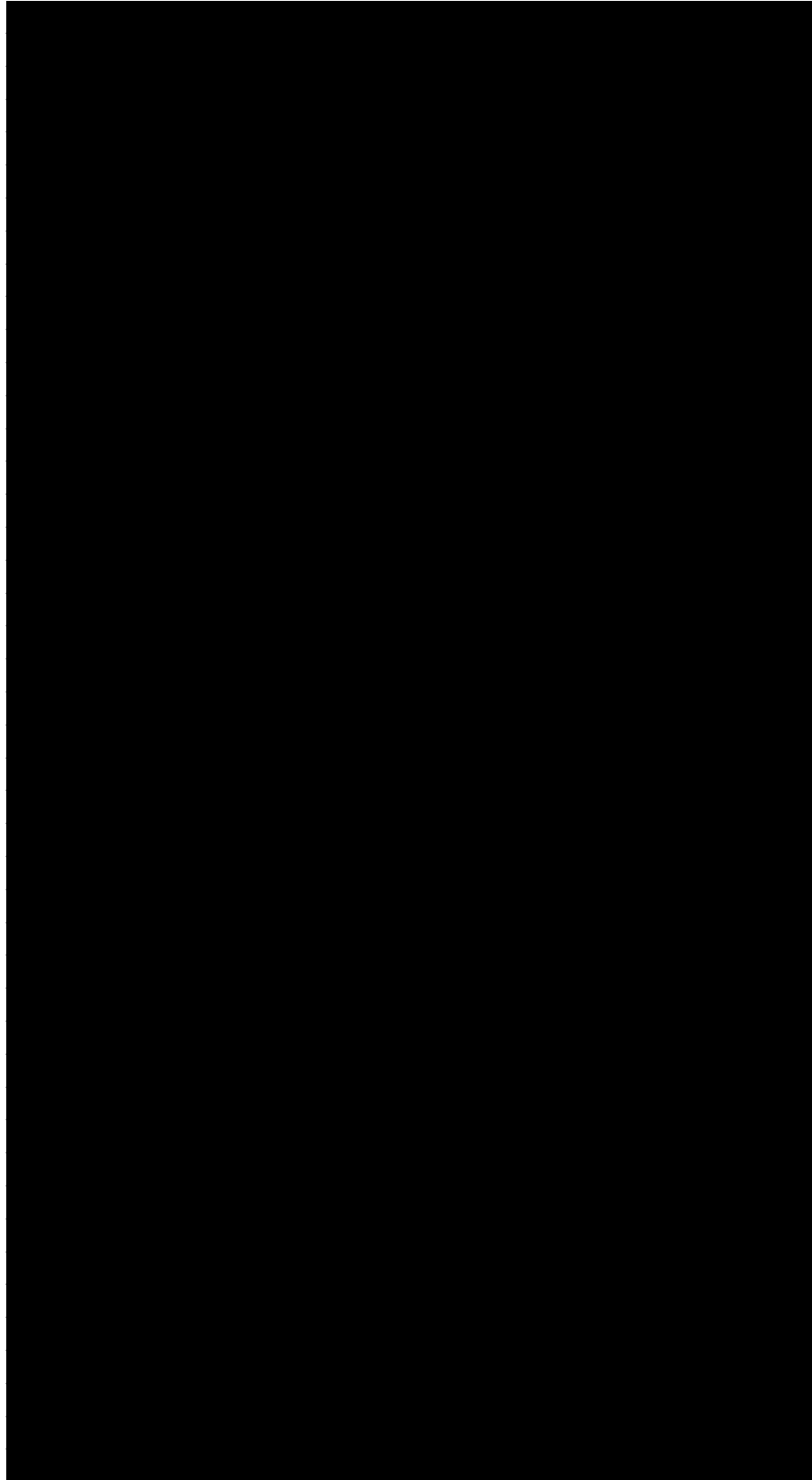
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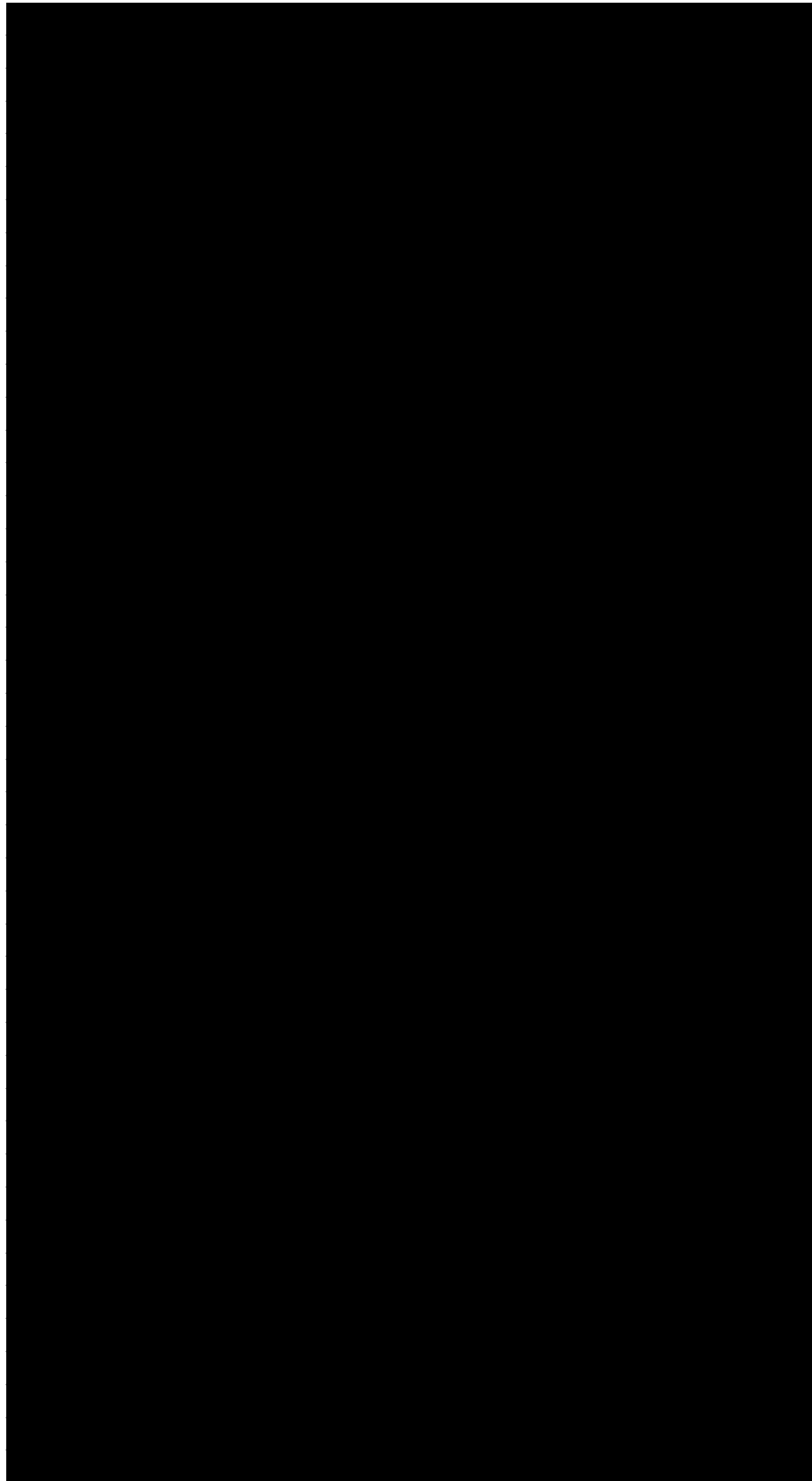


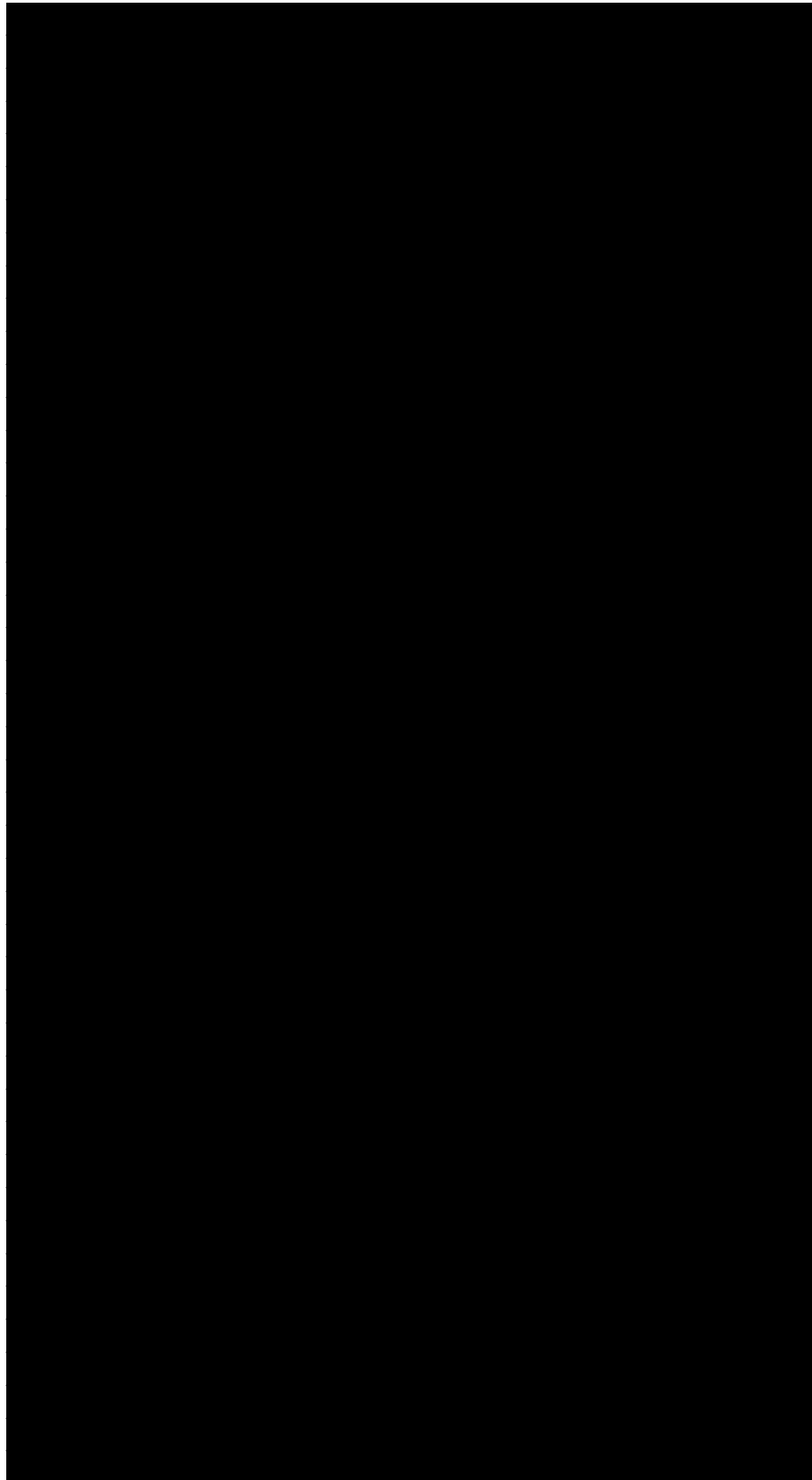


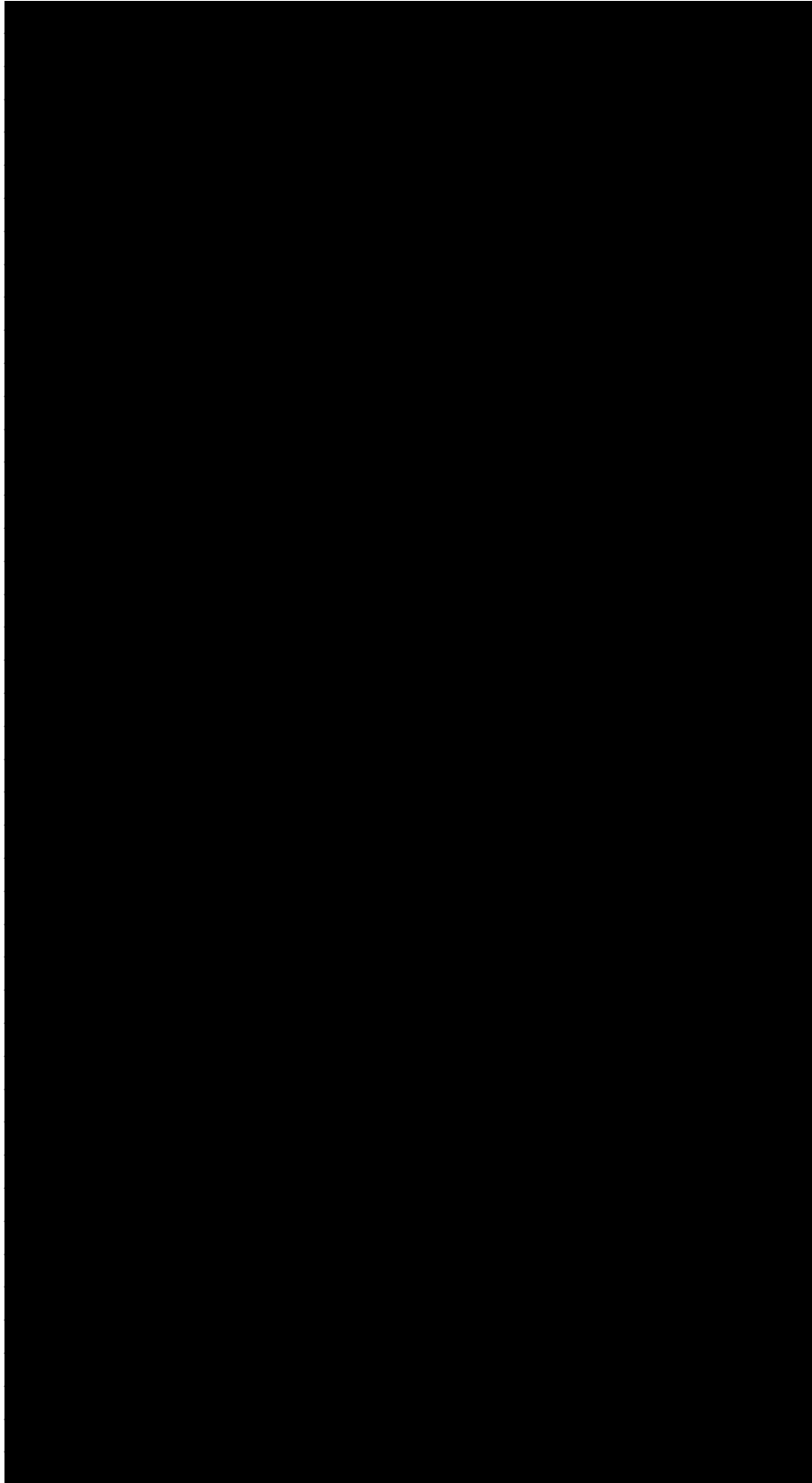
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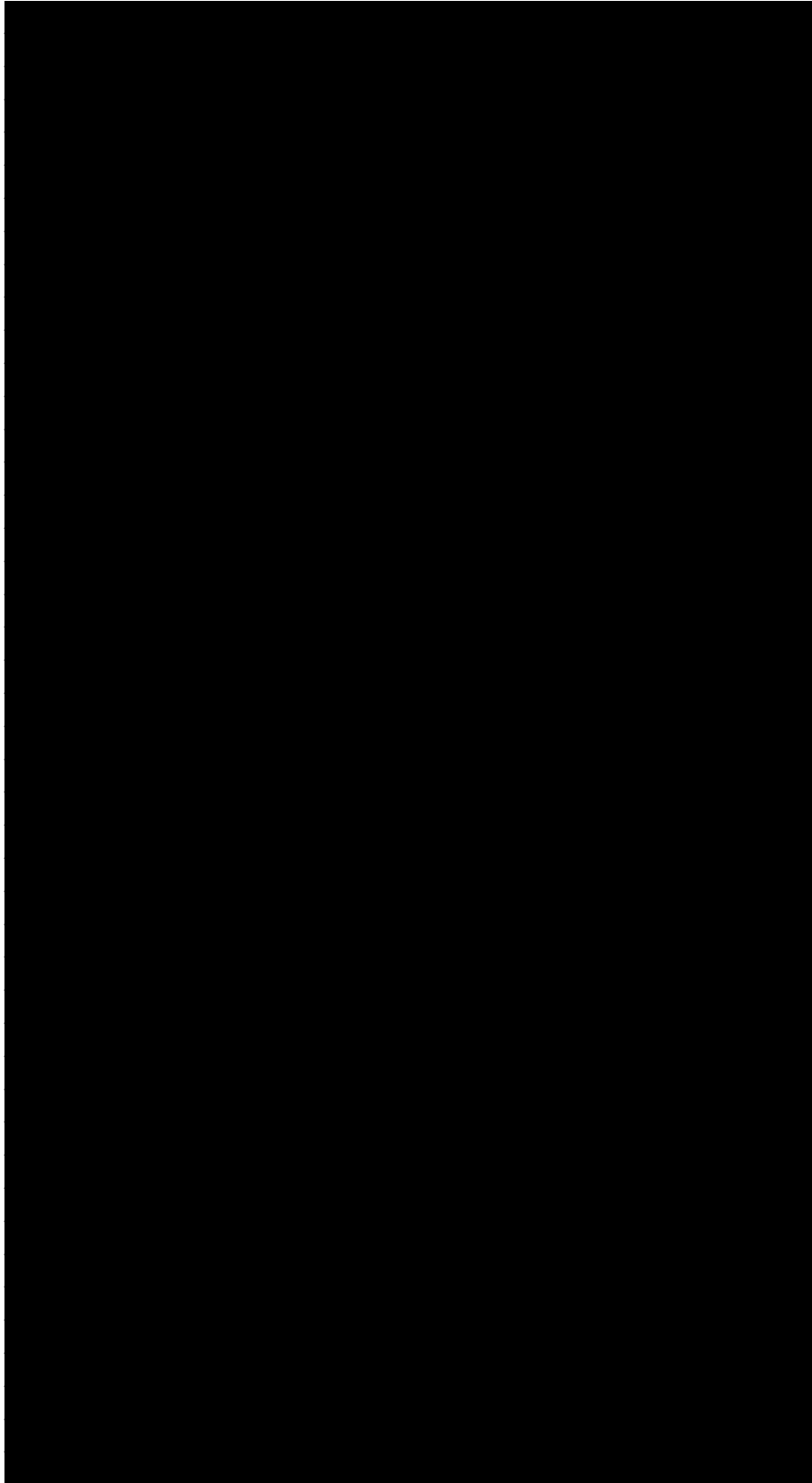




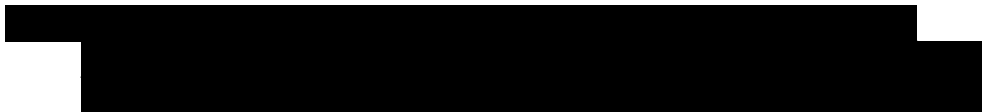
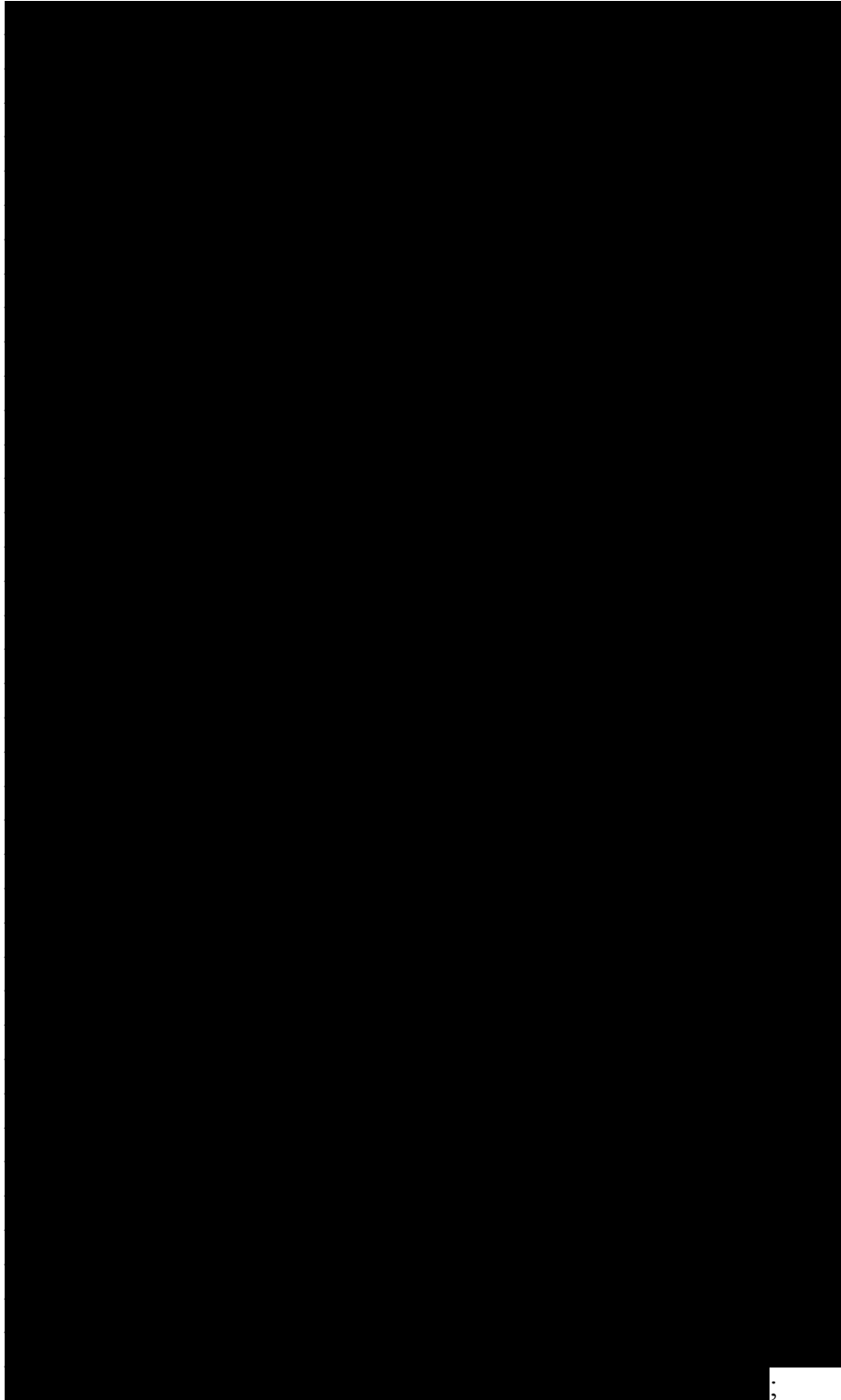




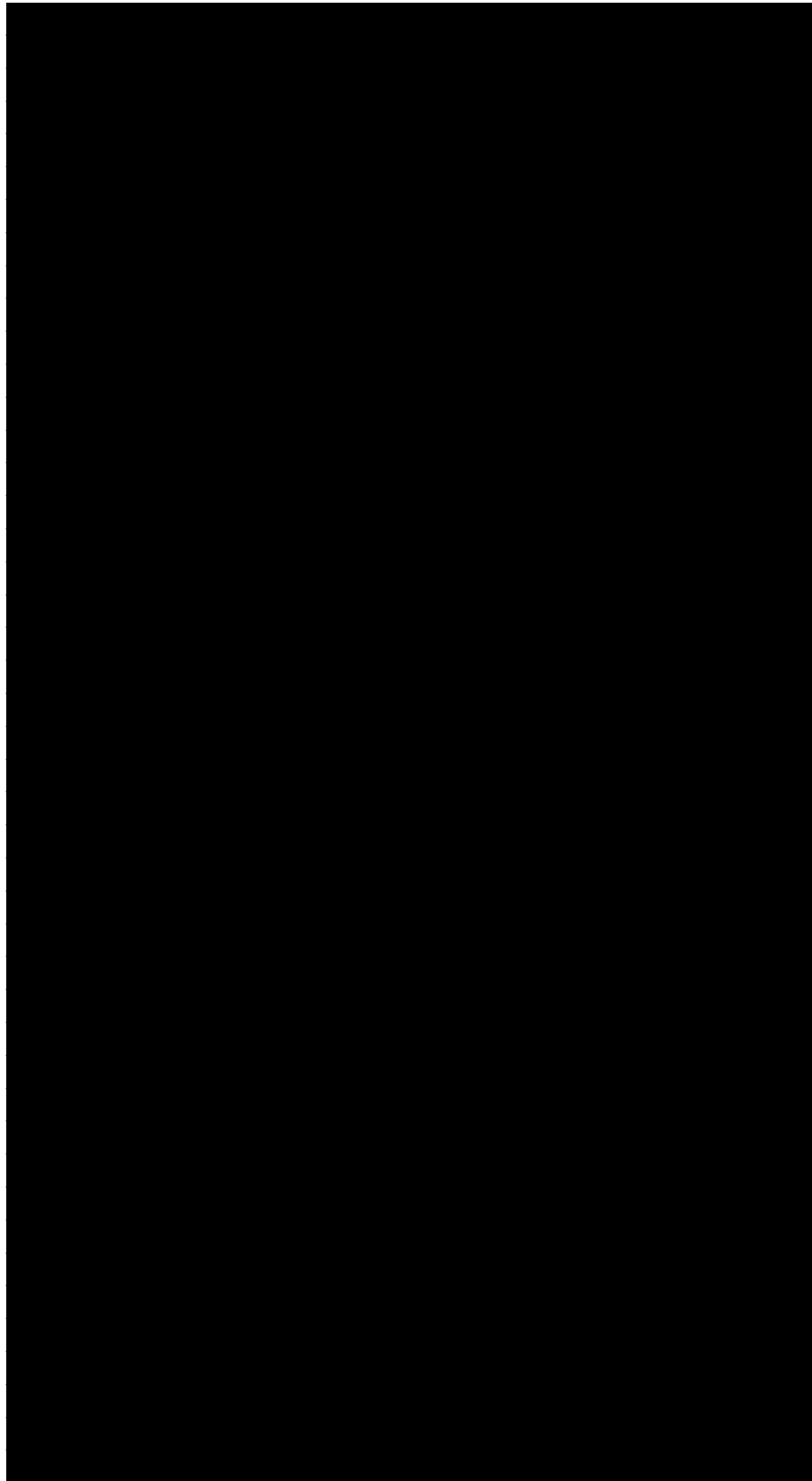
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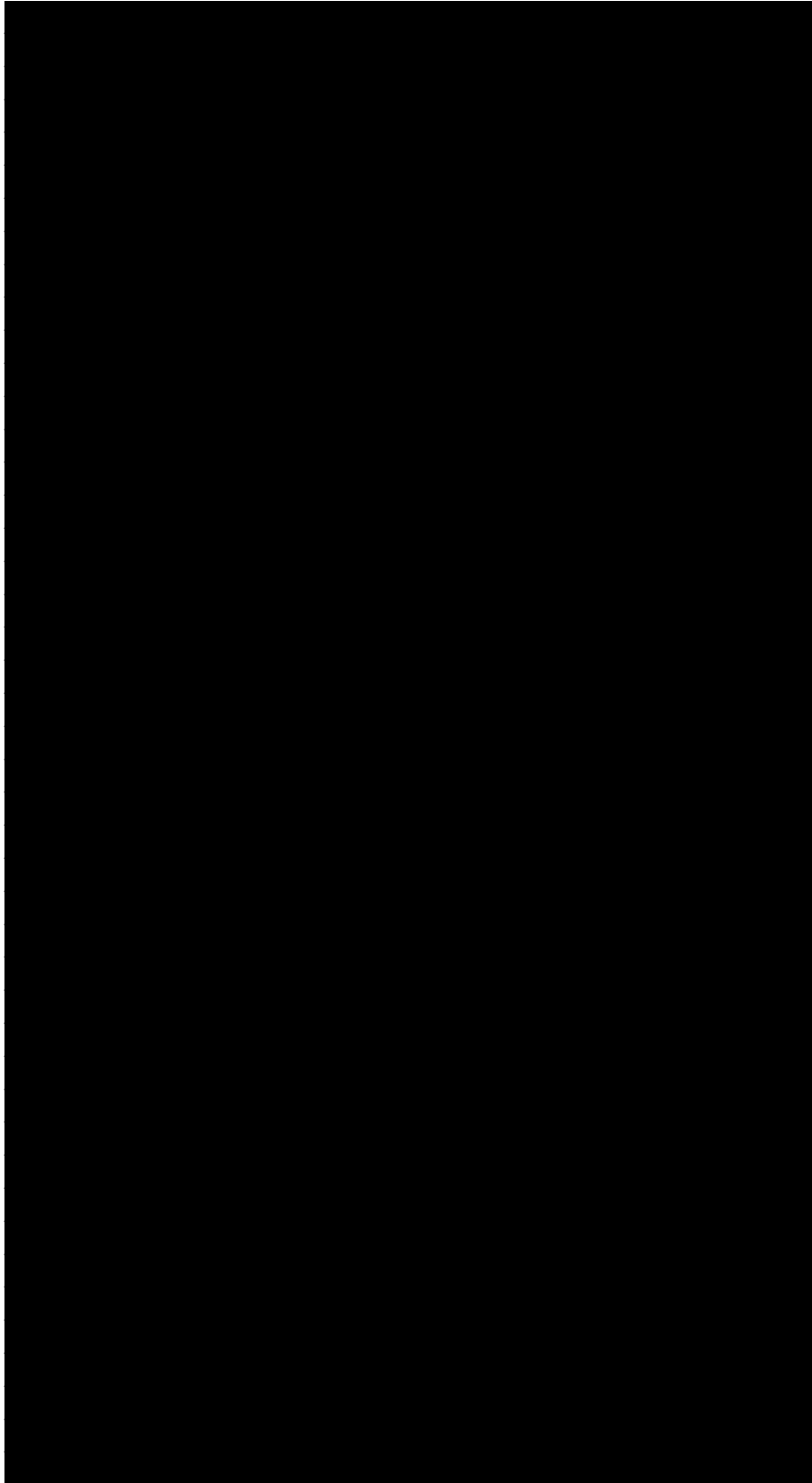
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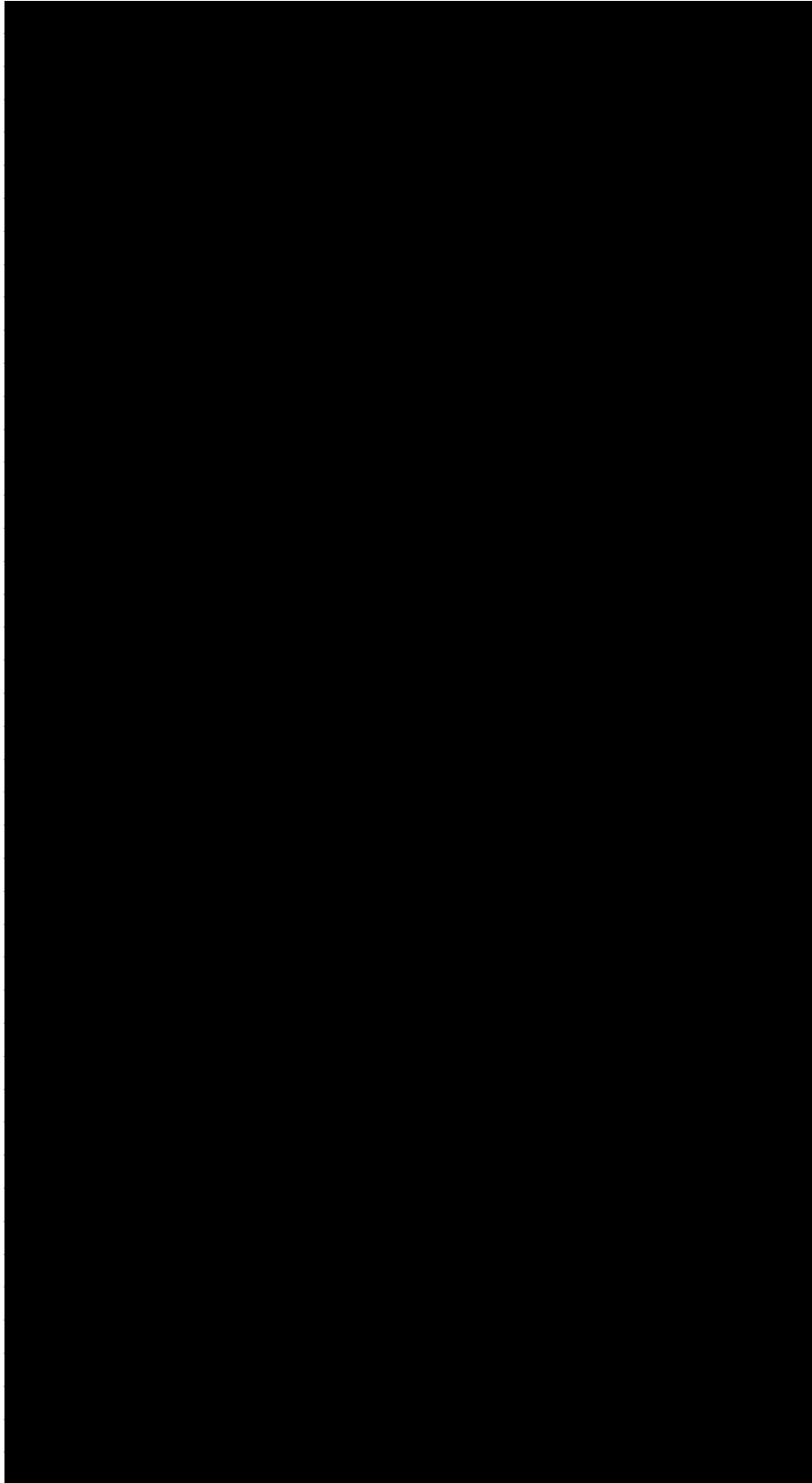
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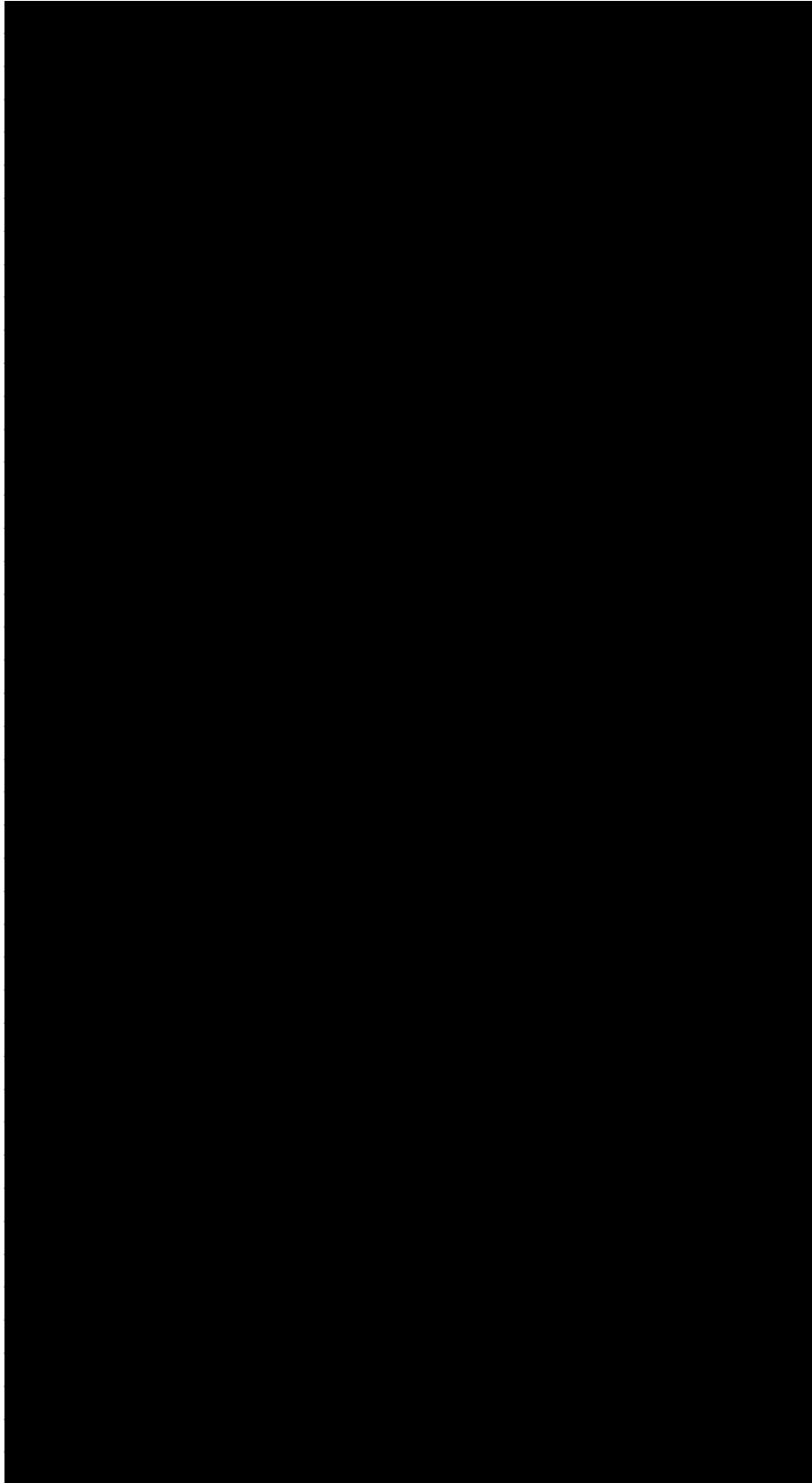
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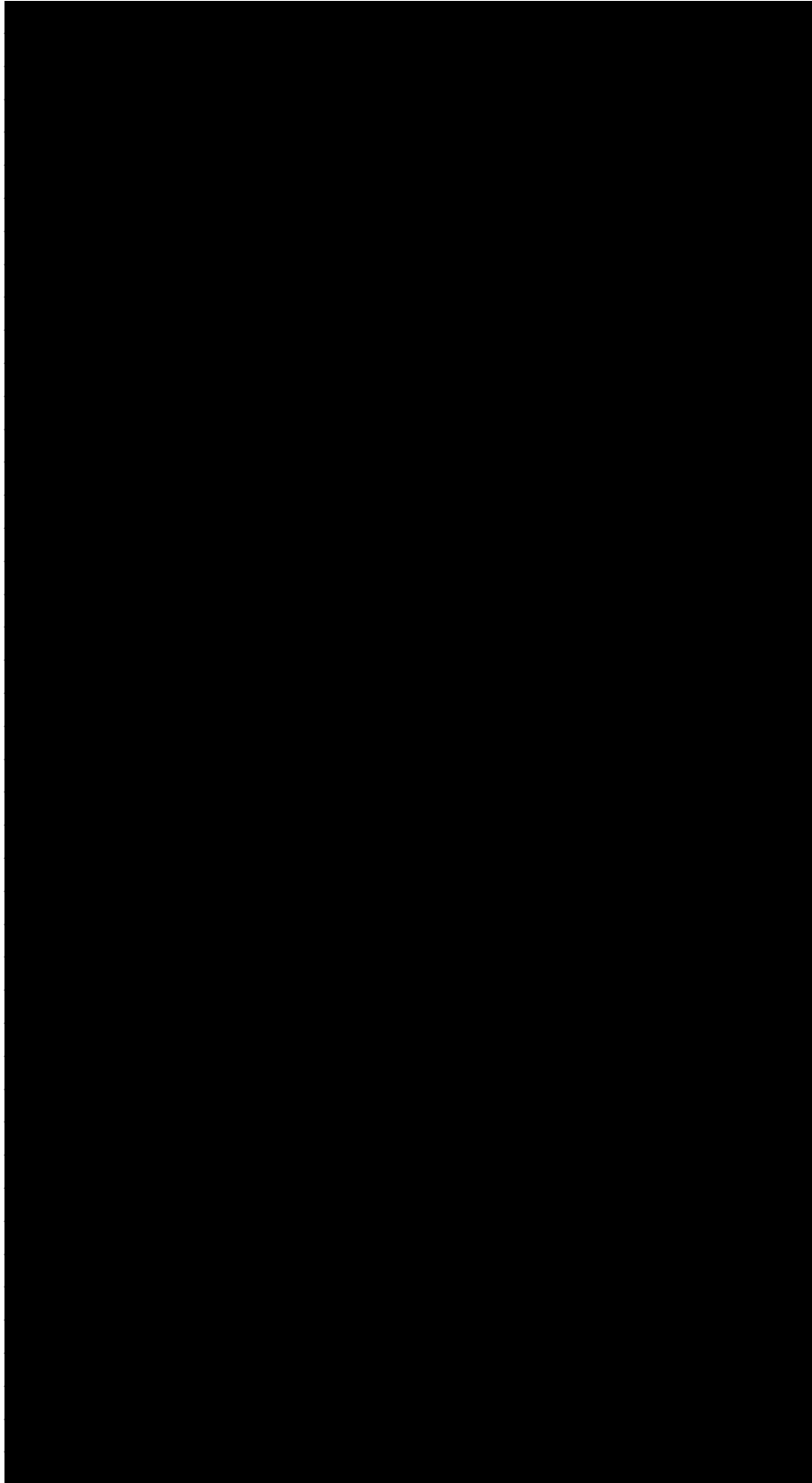


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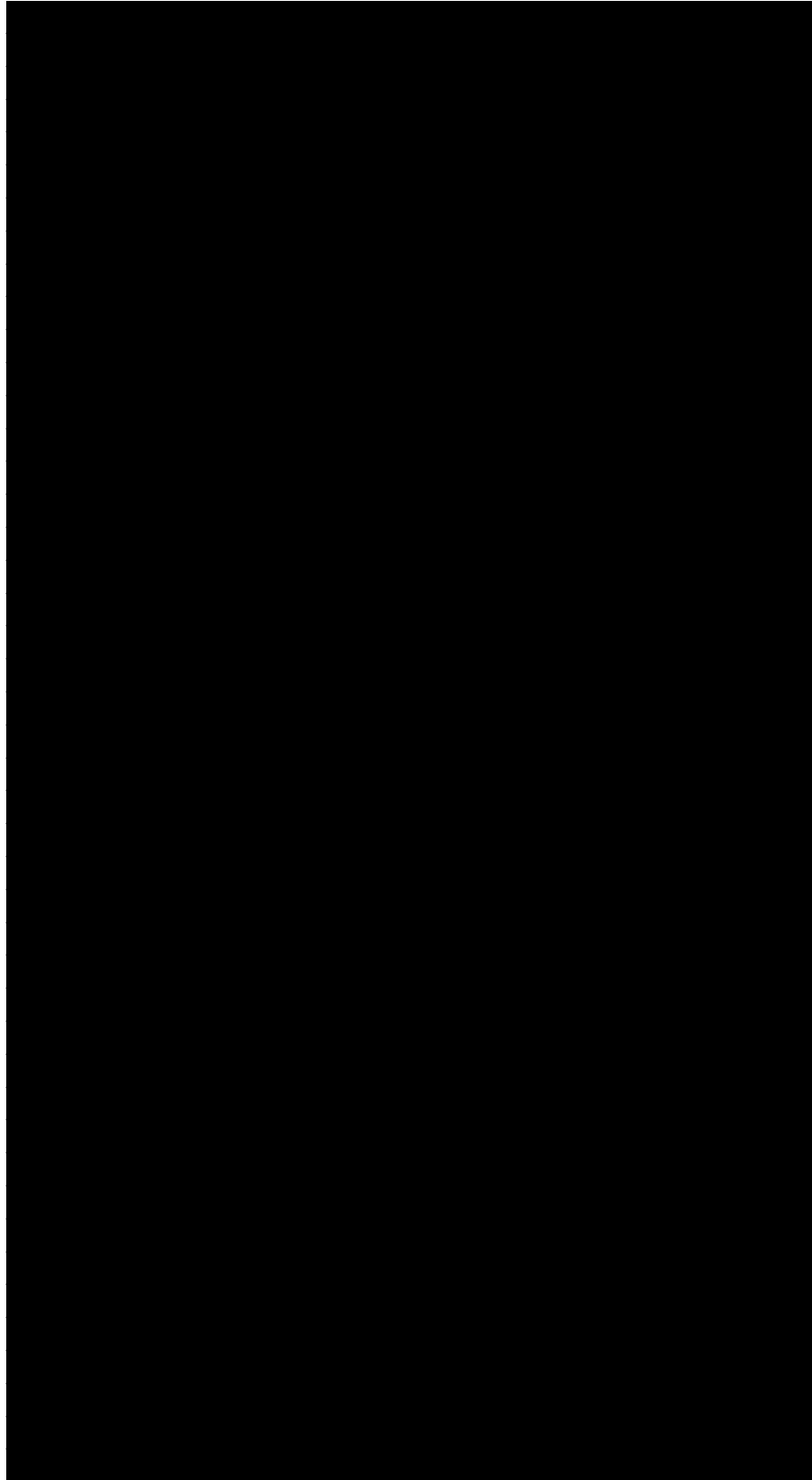


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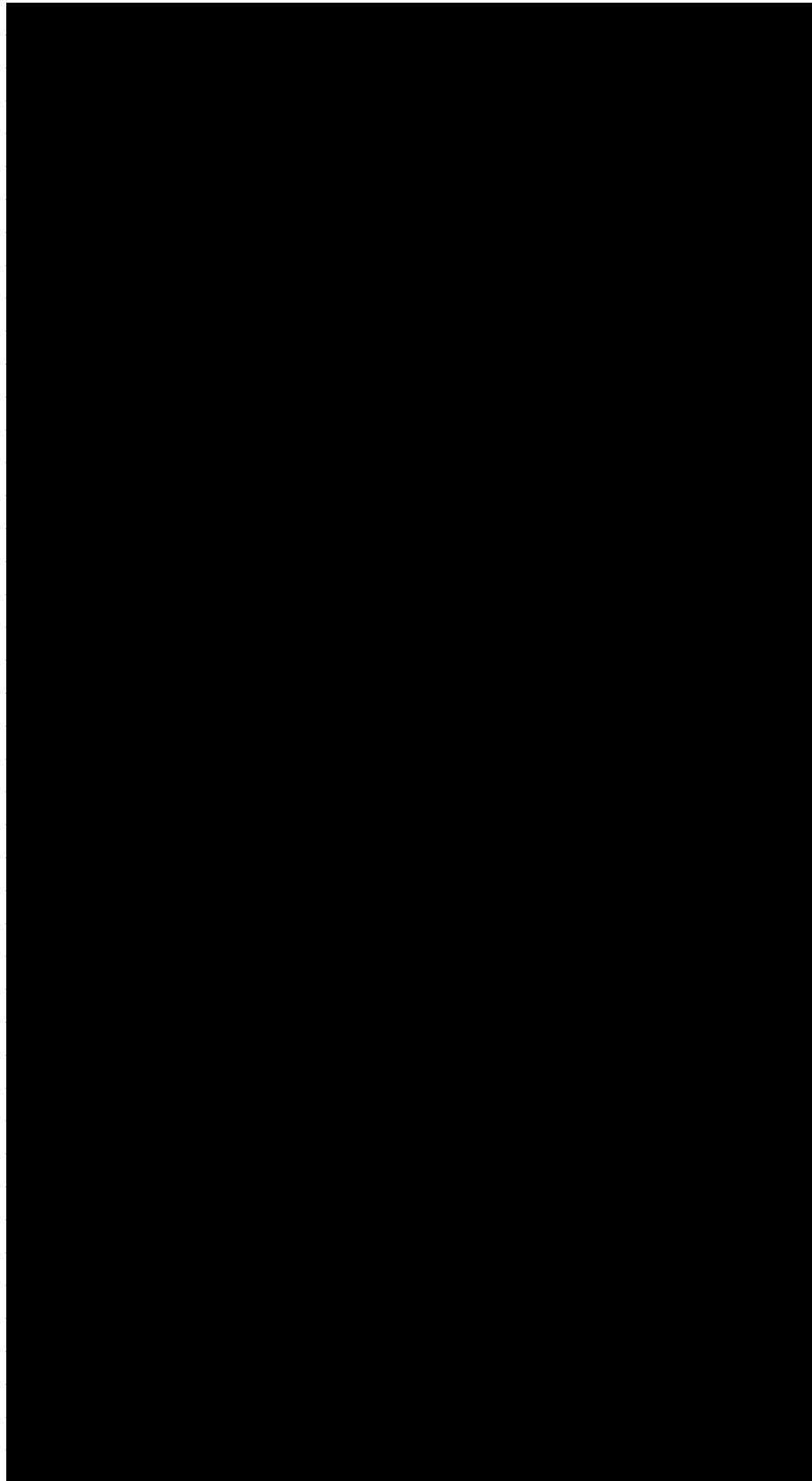




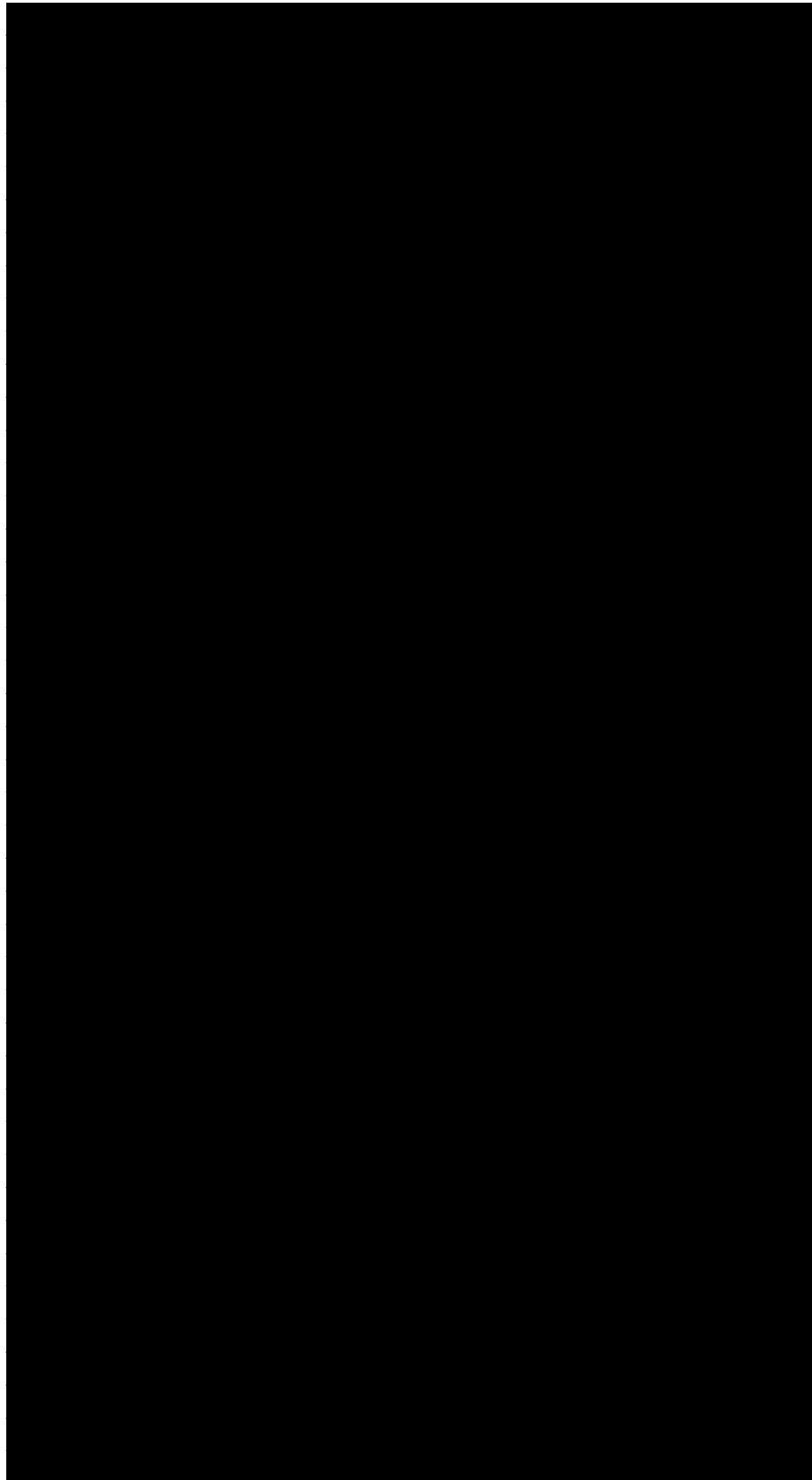
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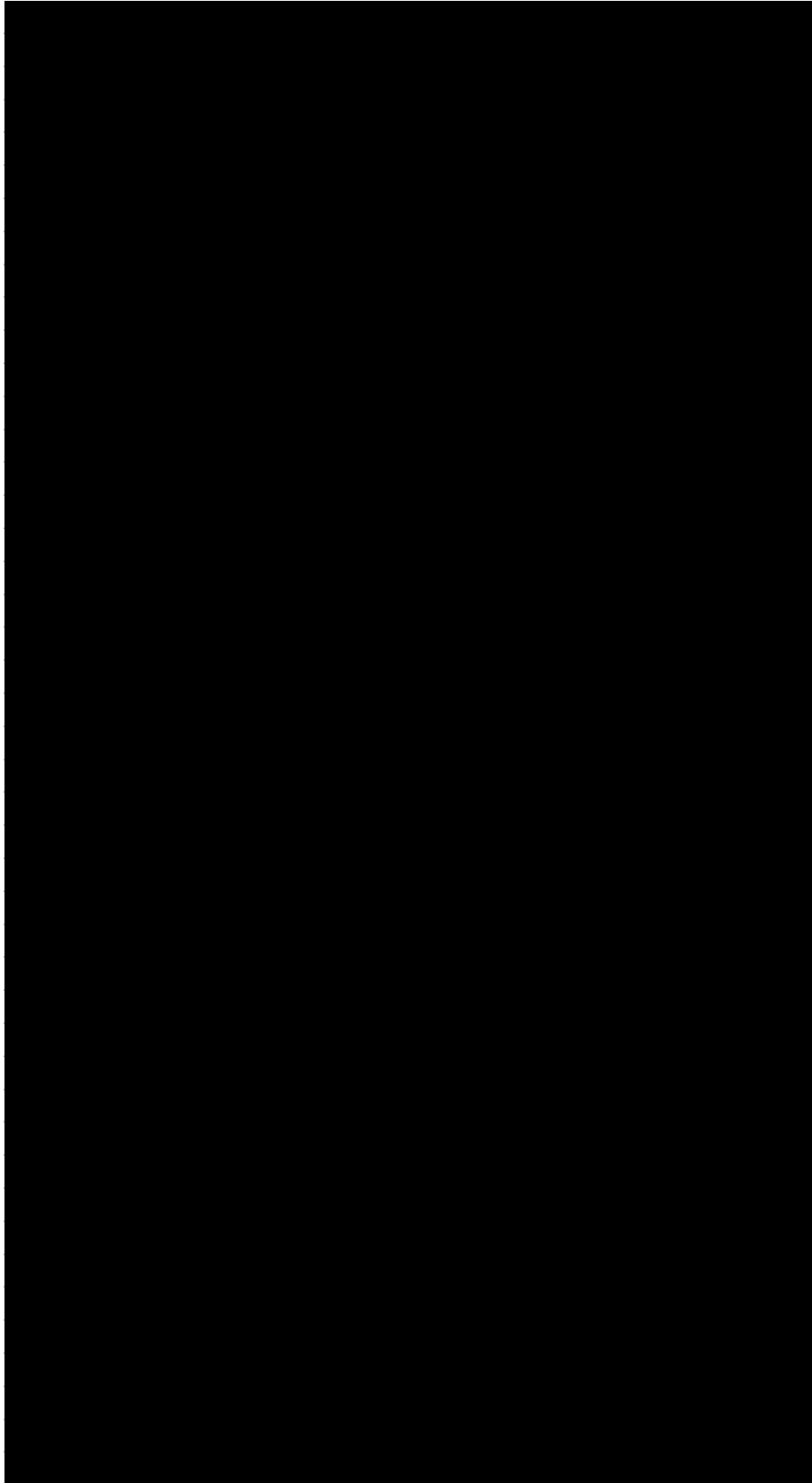
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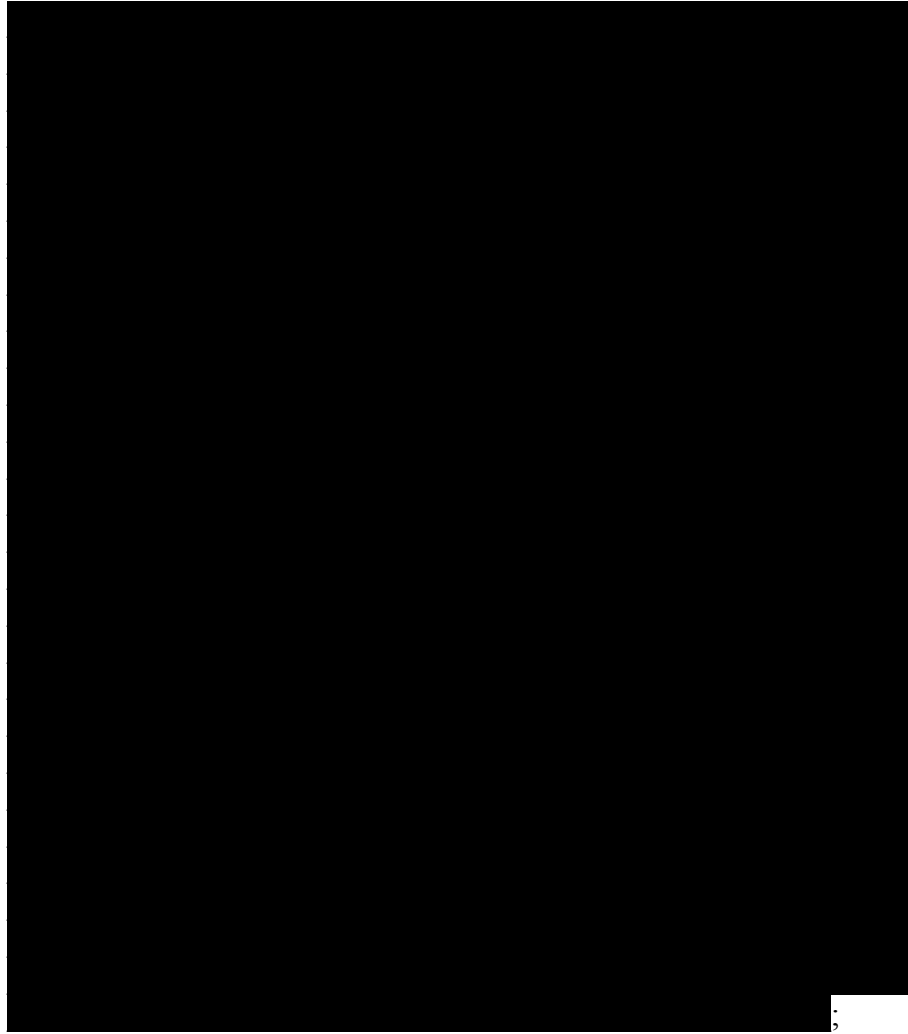
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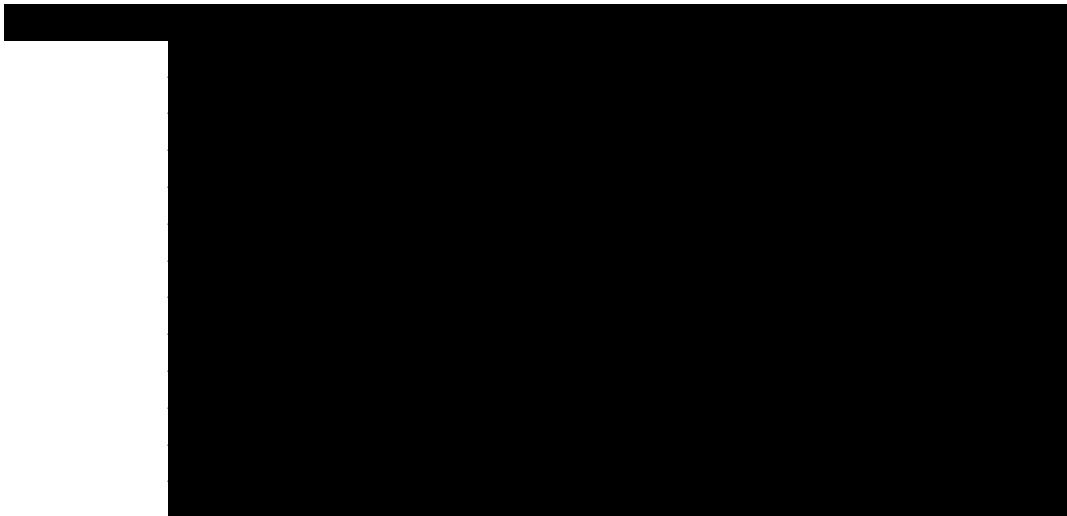
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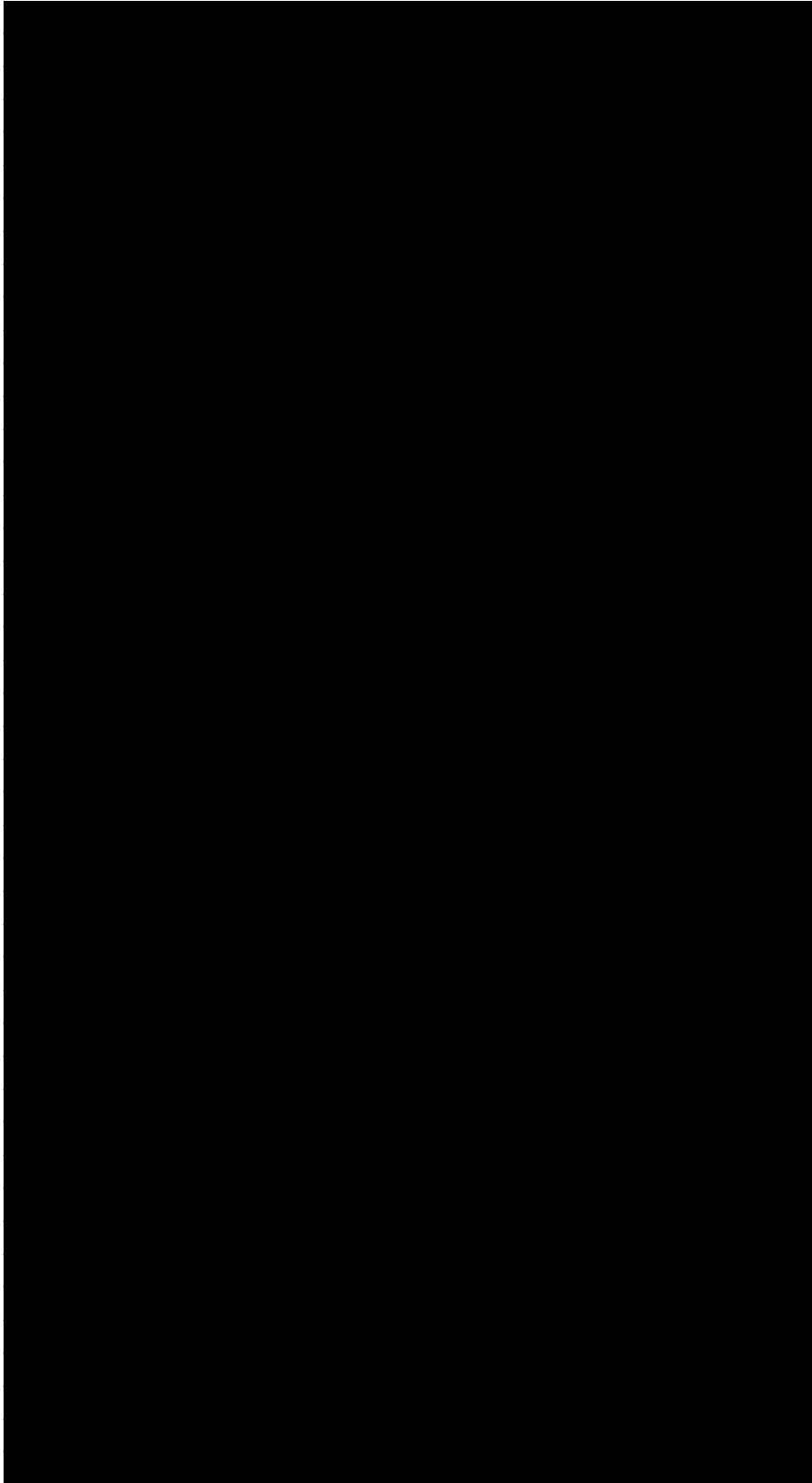
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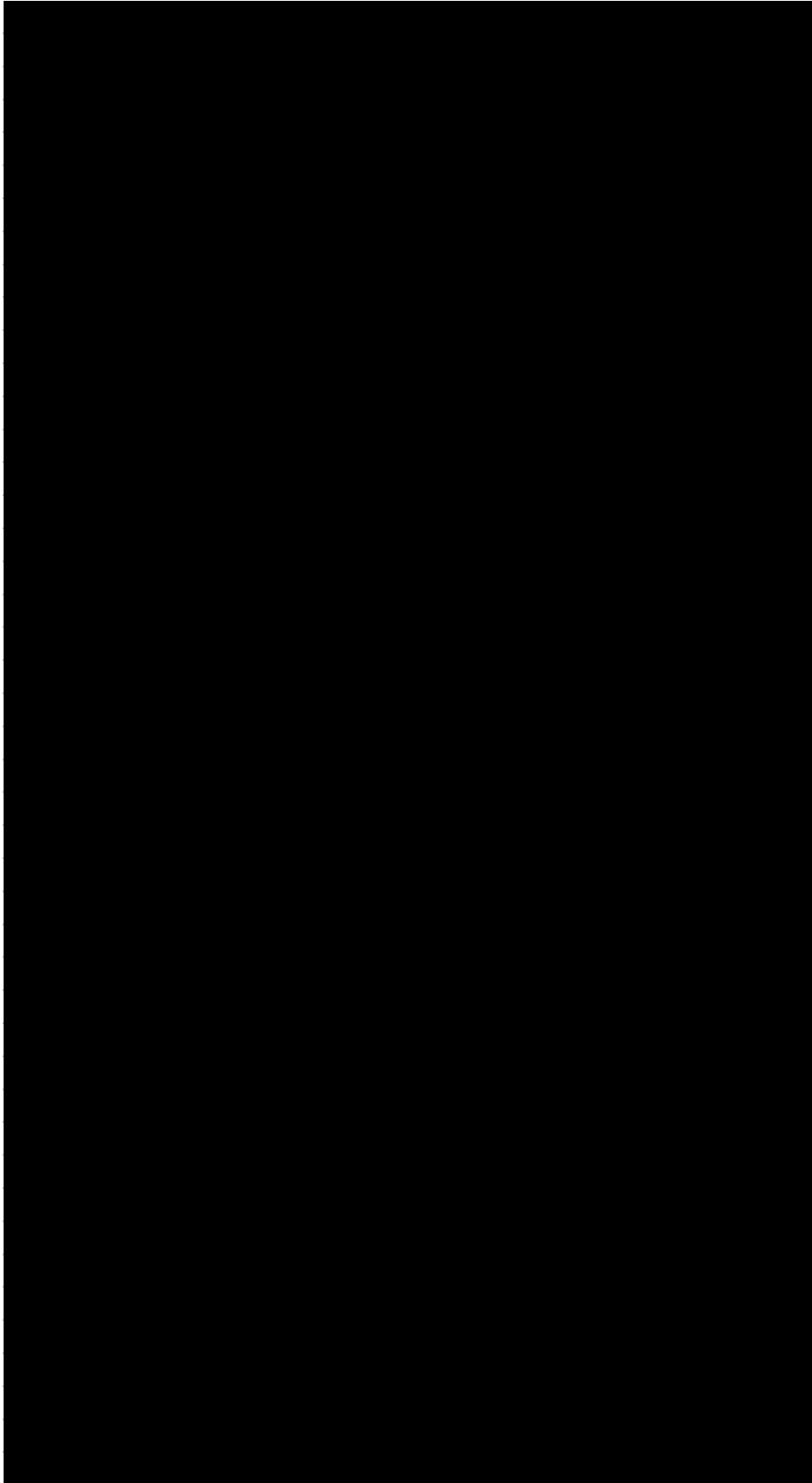
(3) The denial, in whole or in part, of payment for a service...



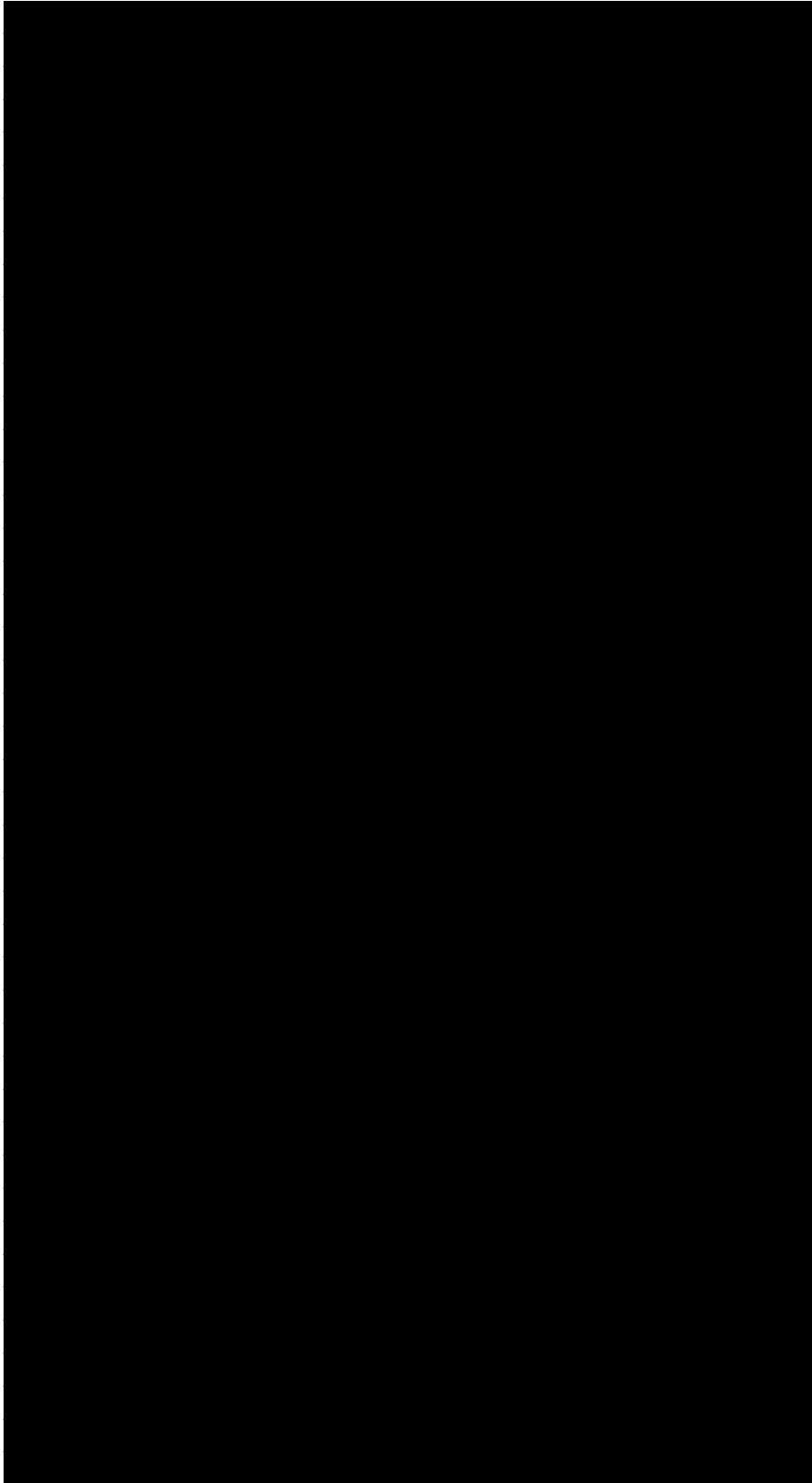
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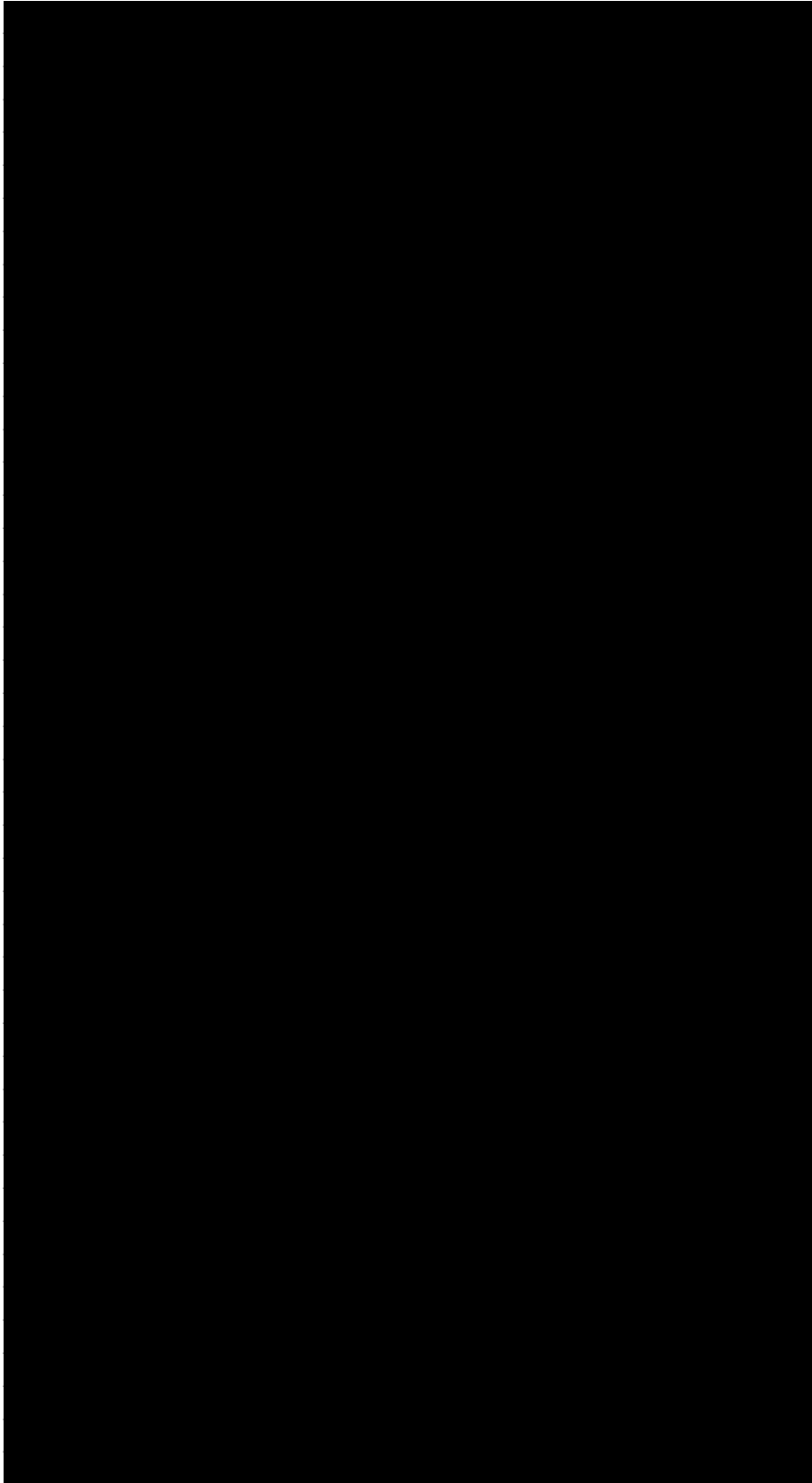
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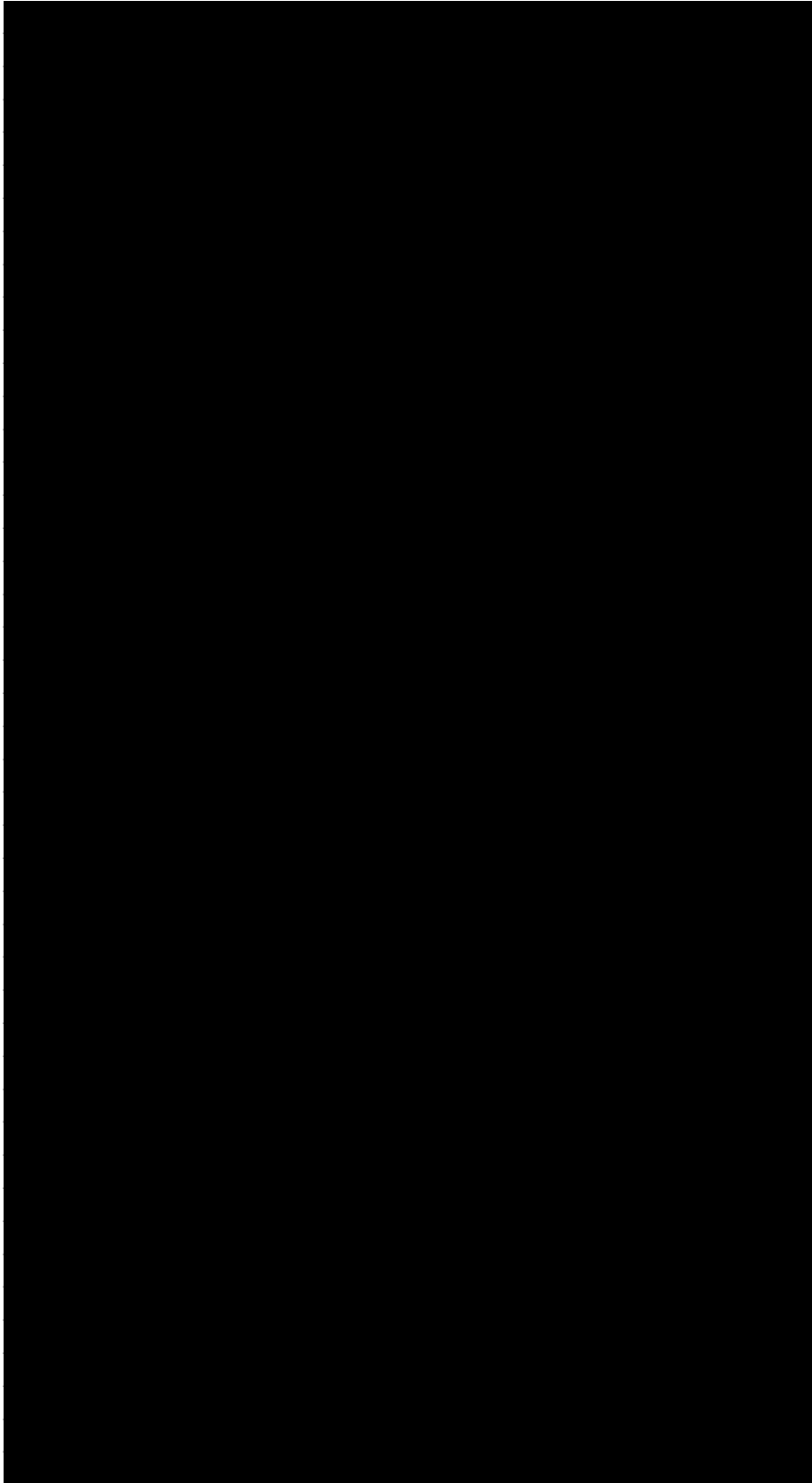
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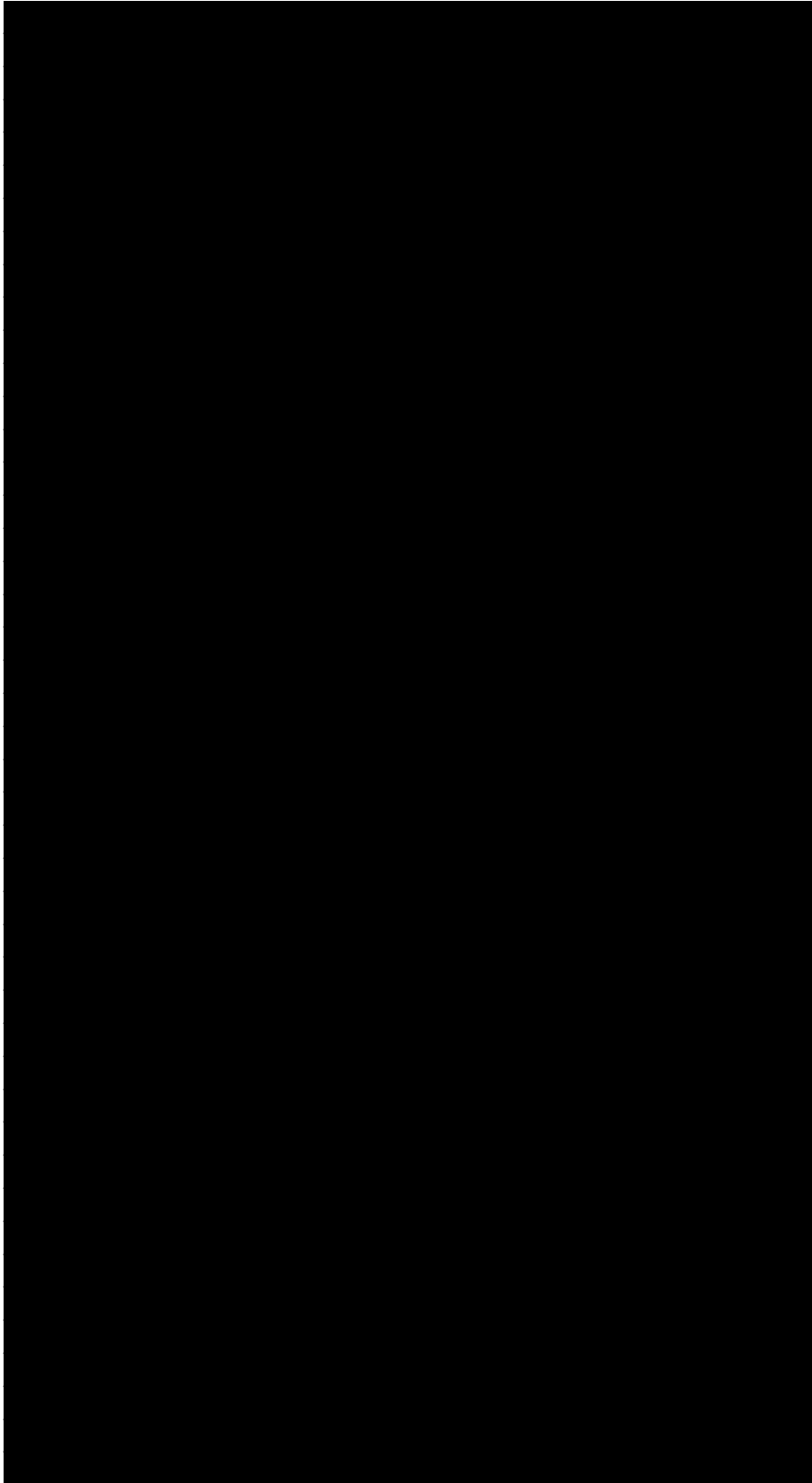
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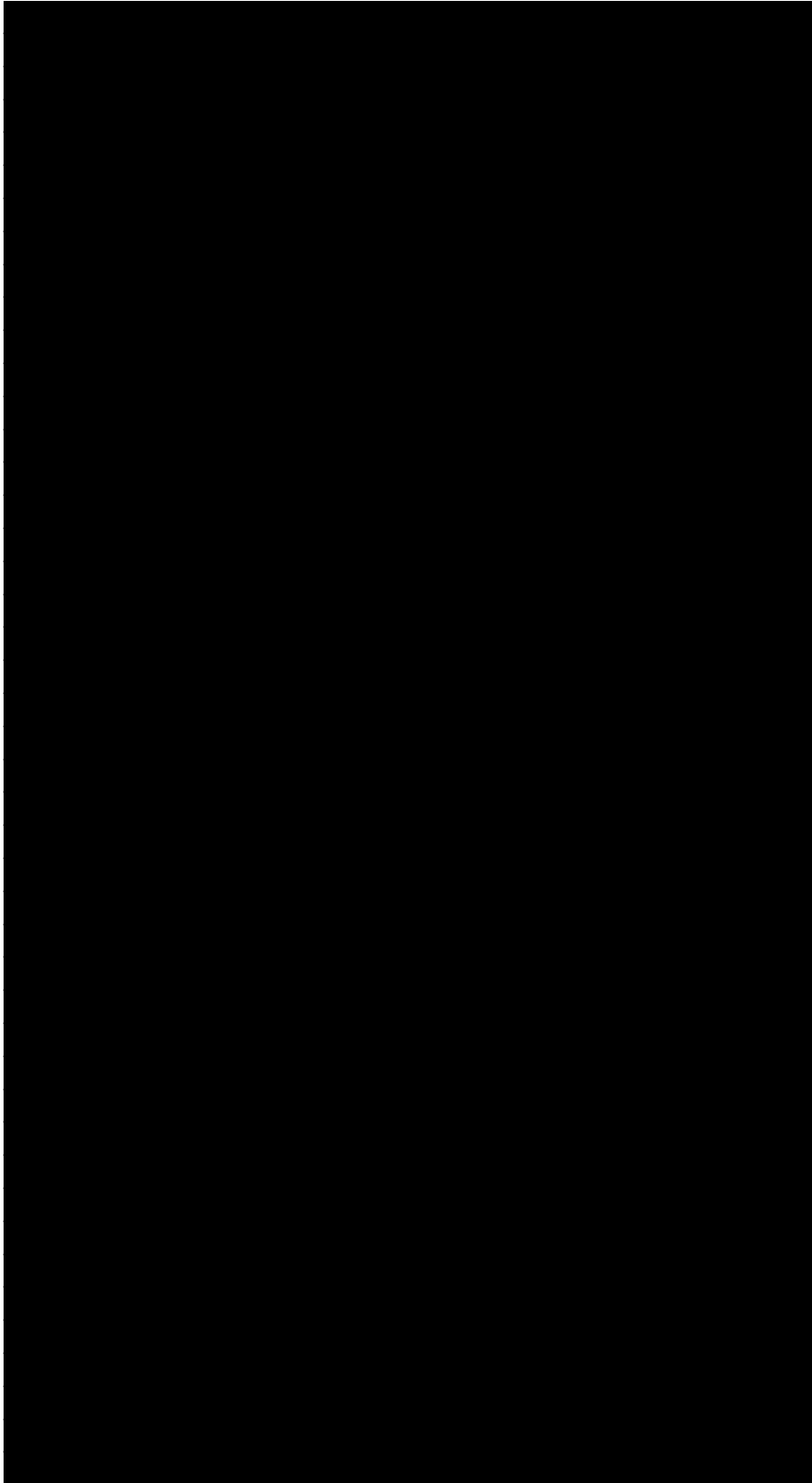
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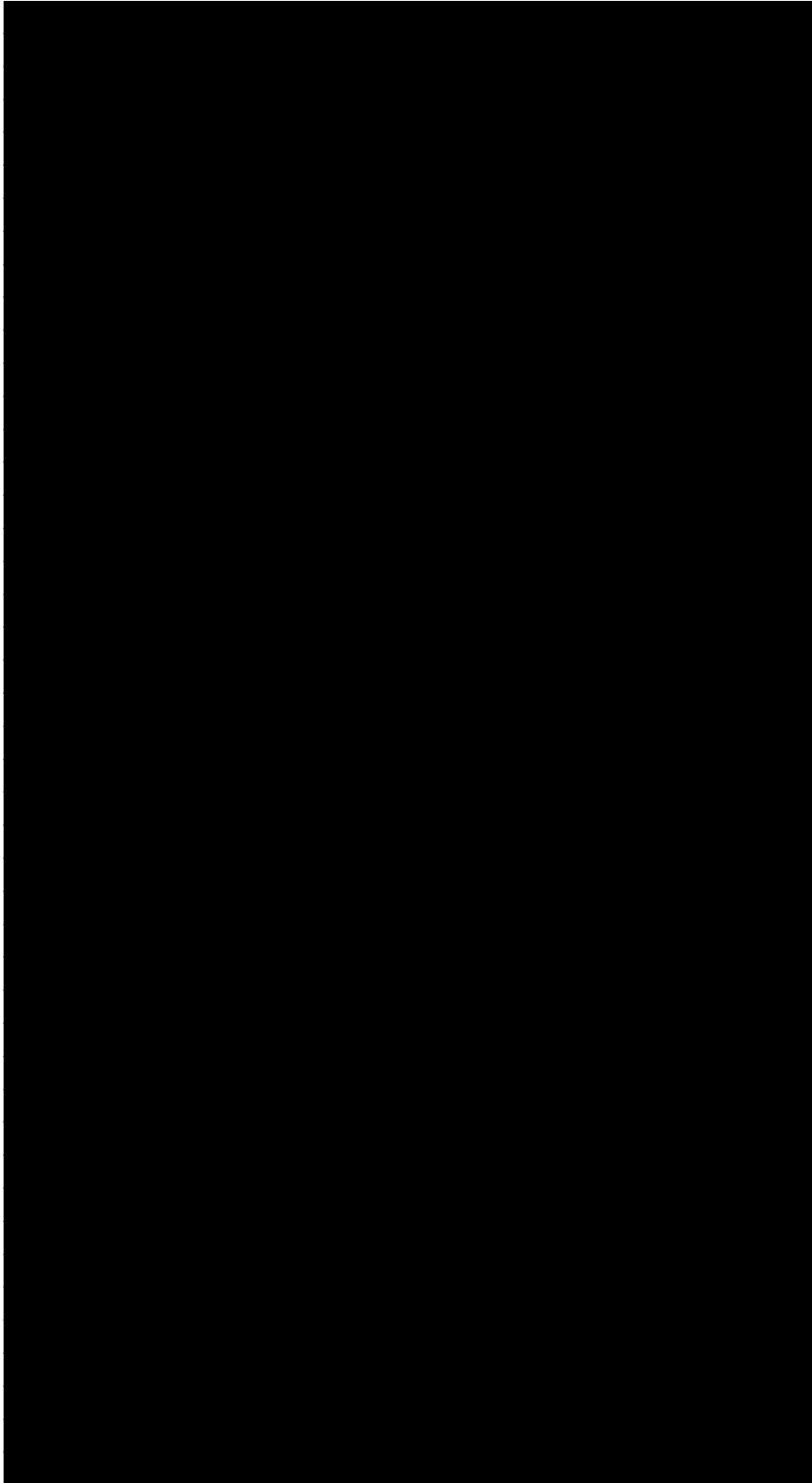


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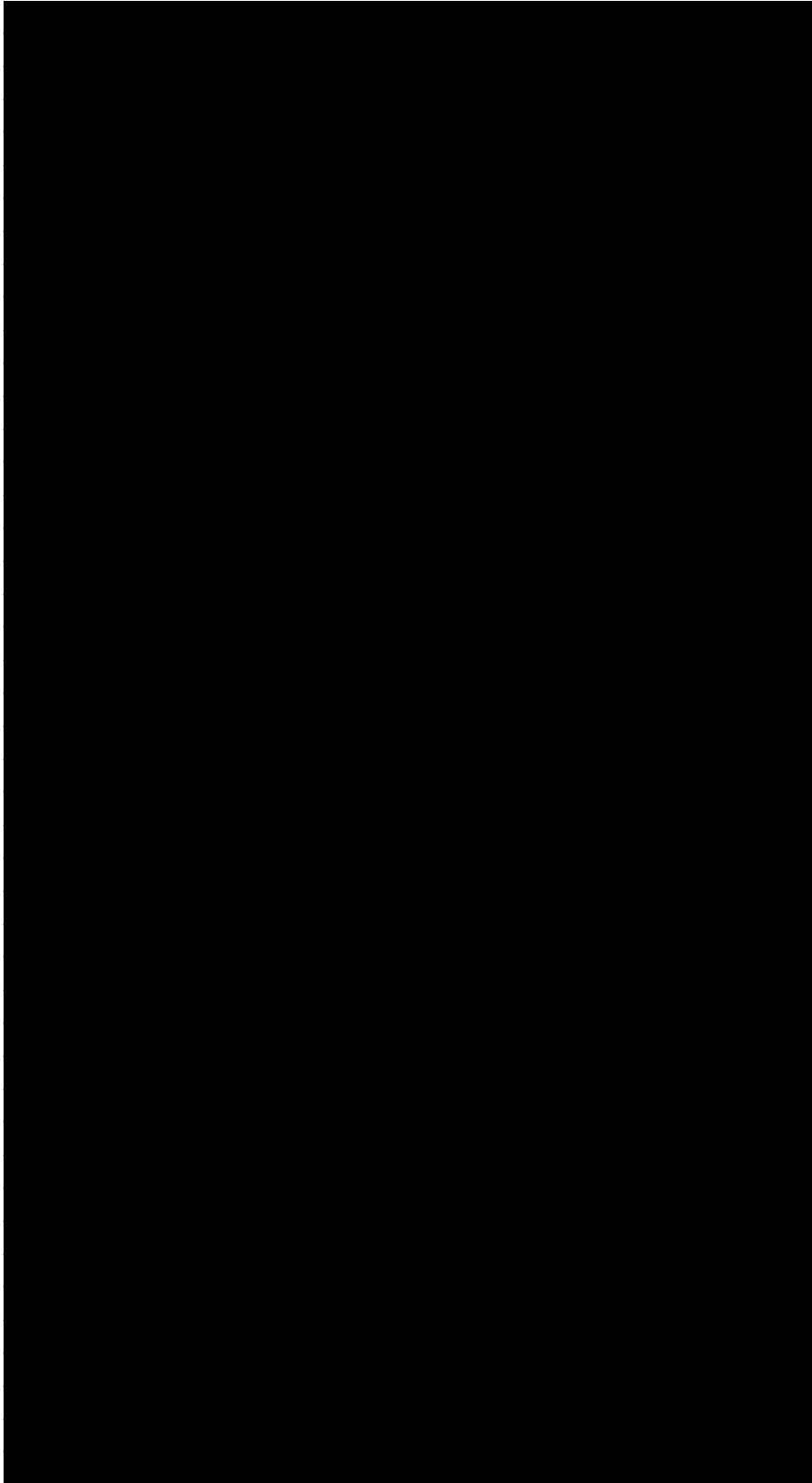


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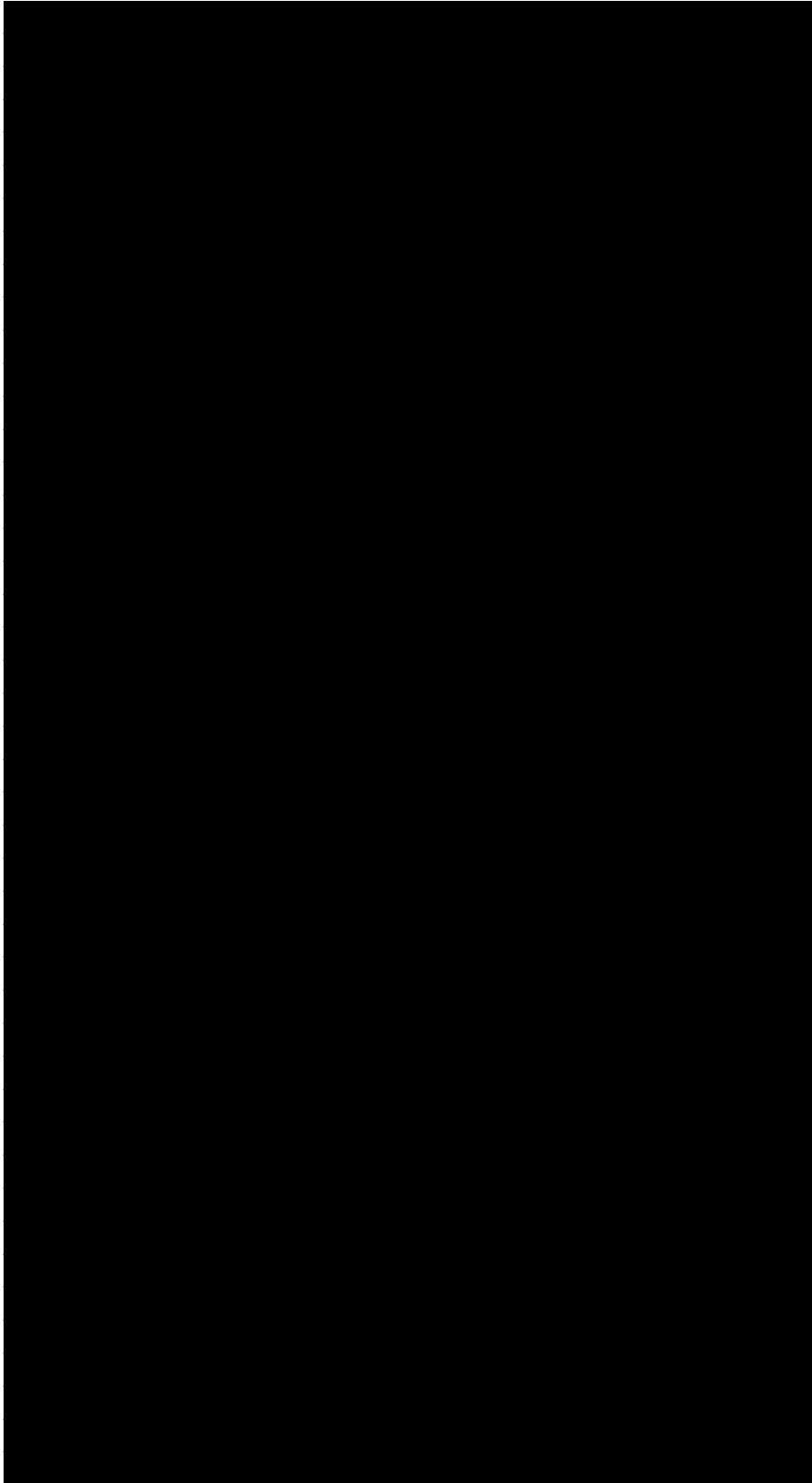
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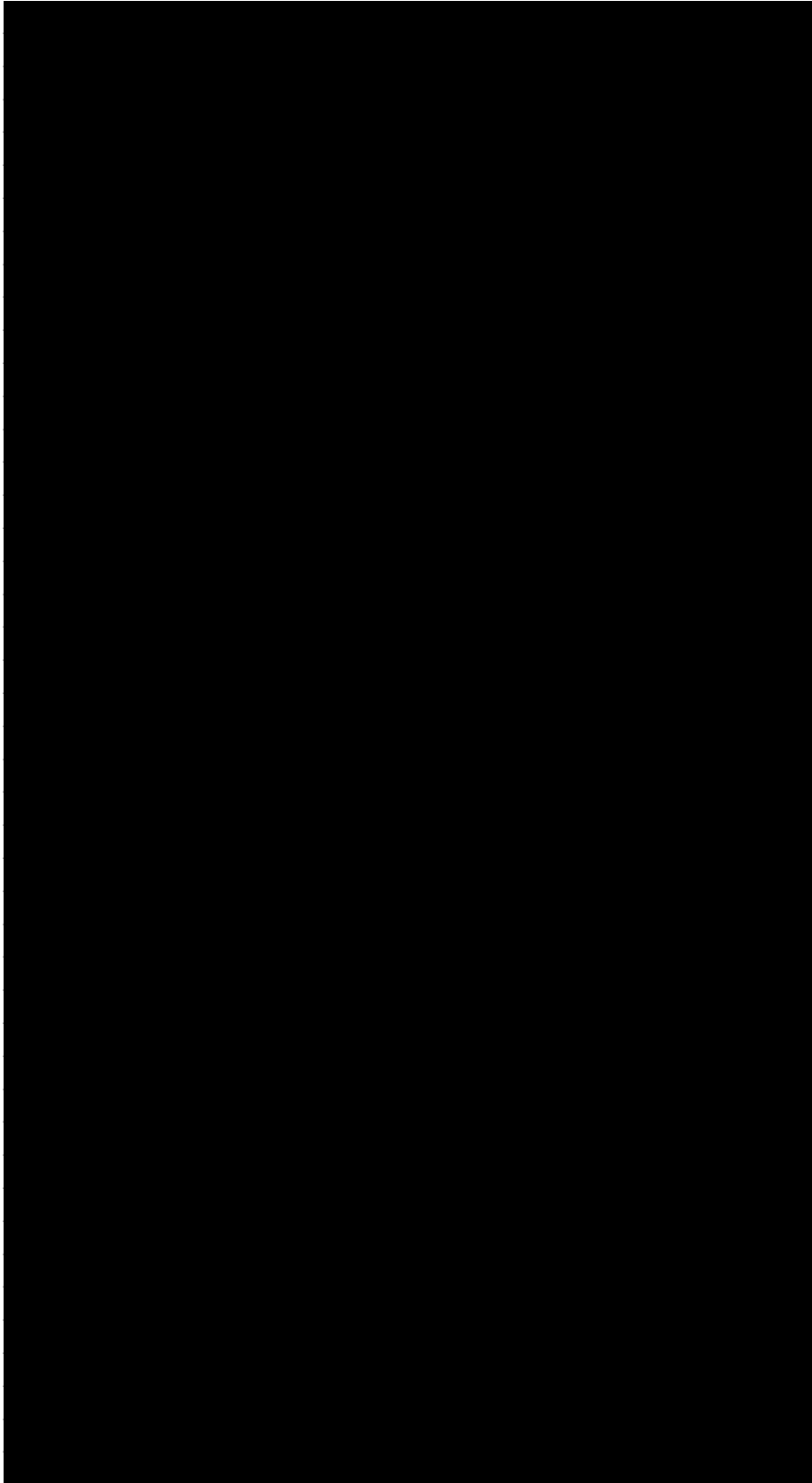
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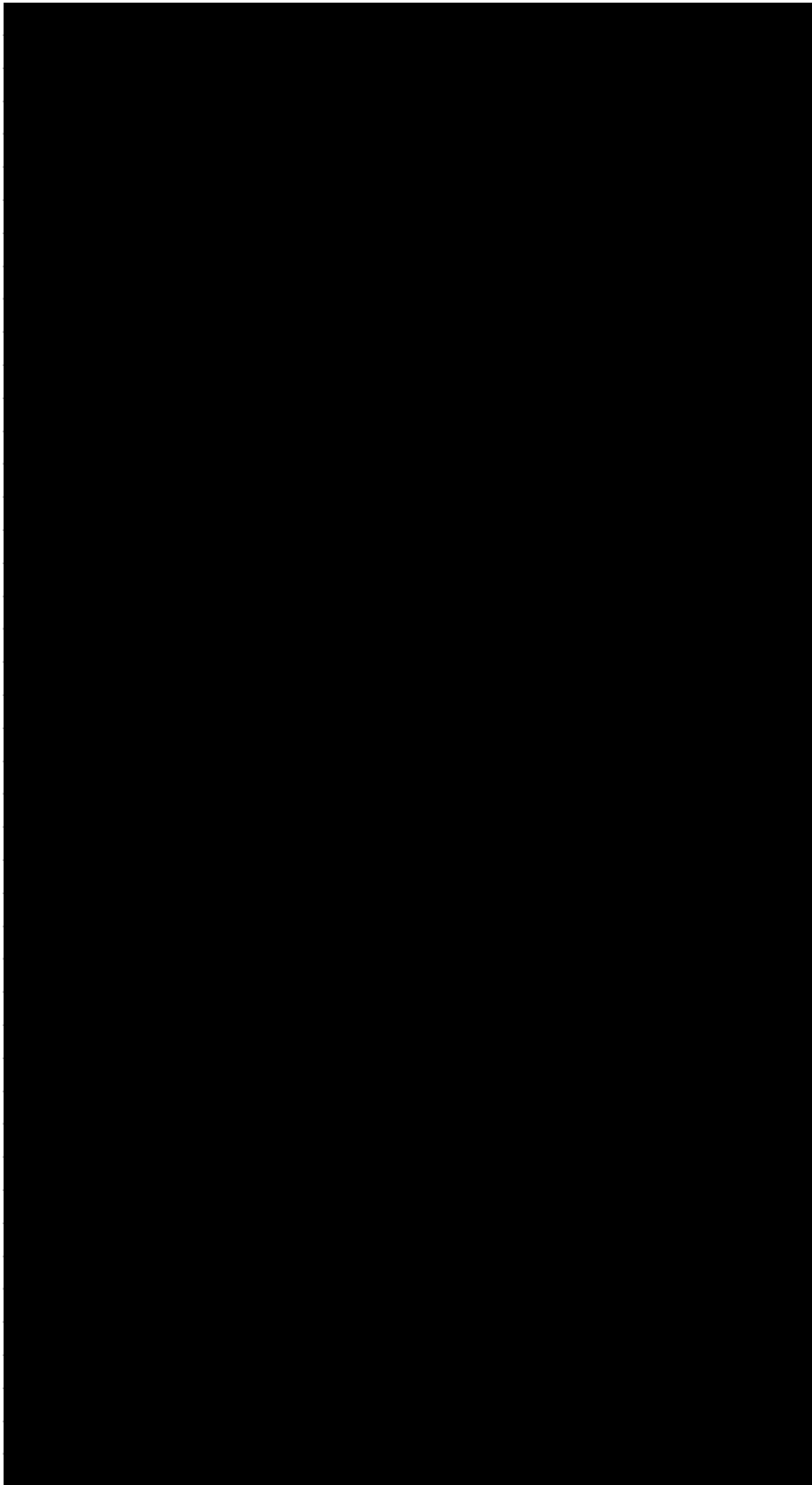
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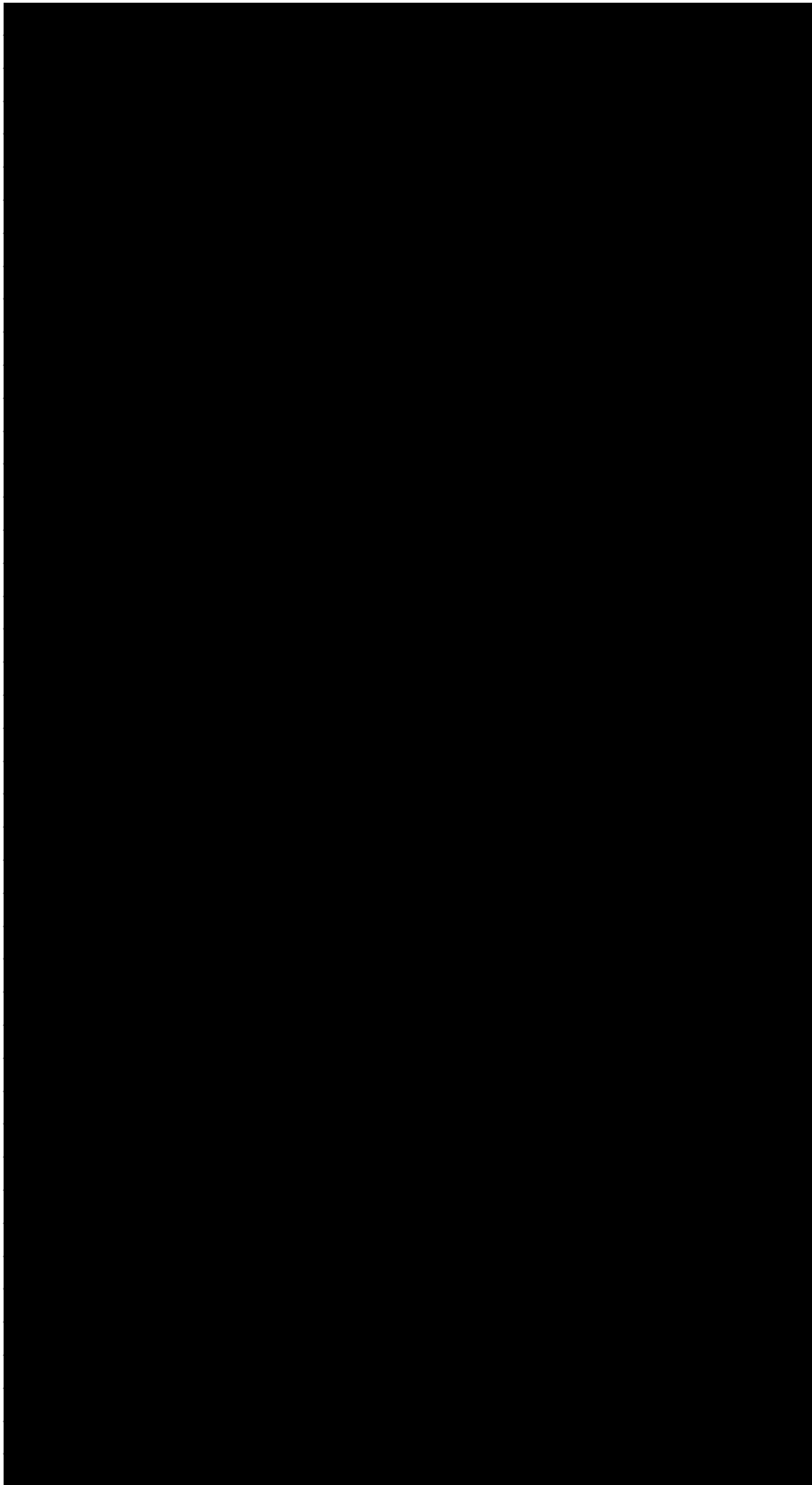
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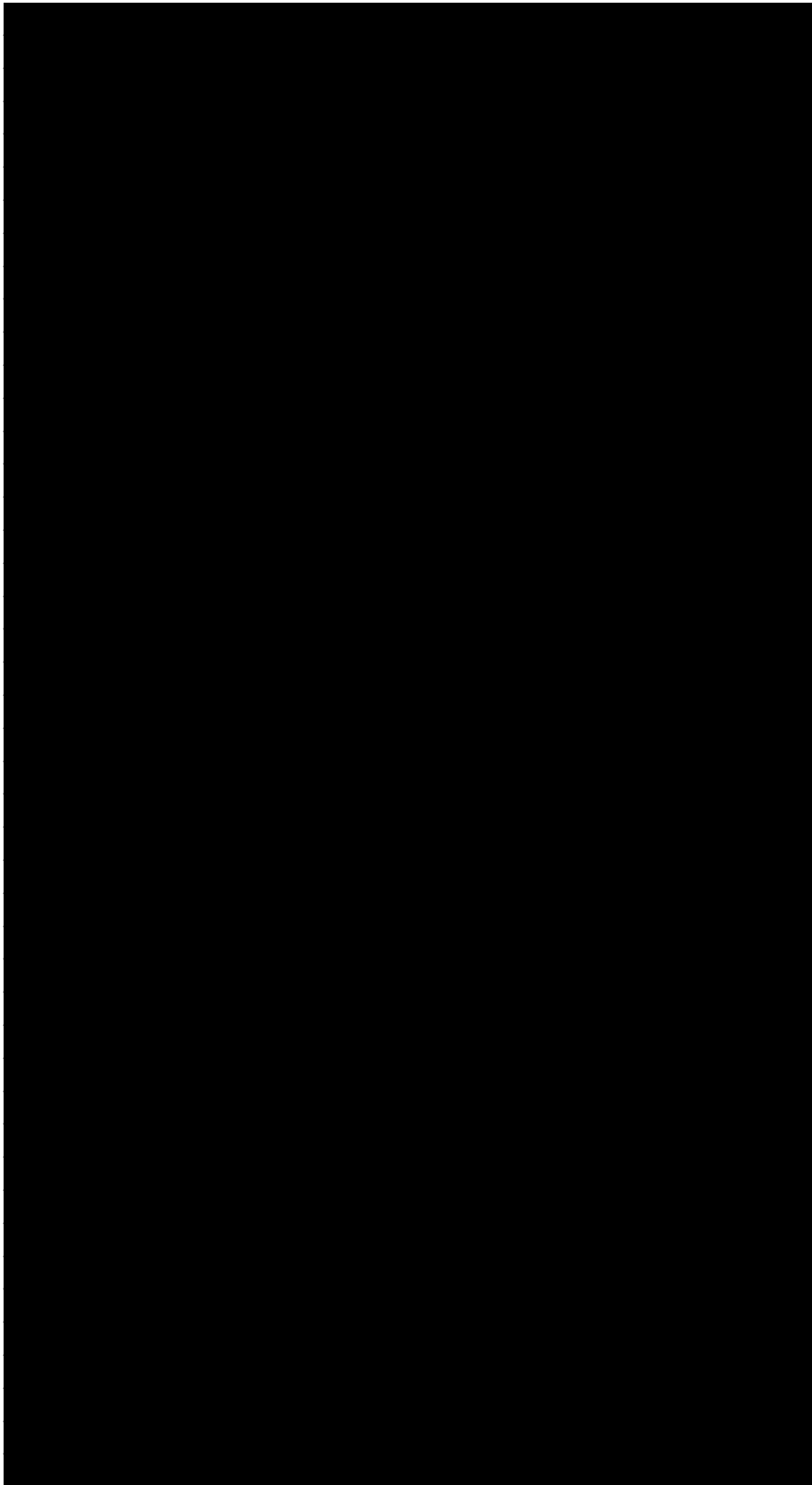
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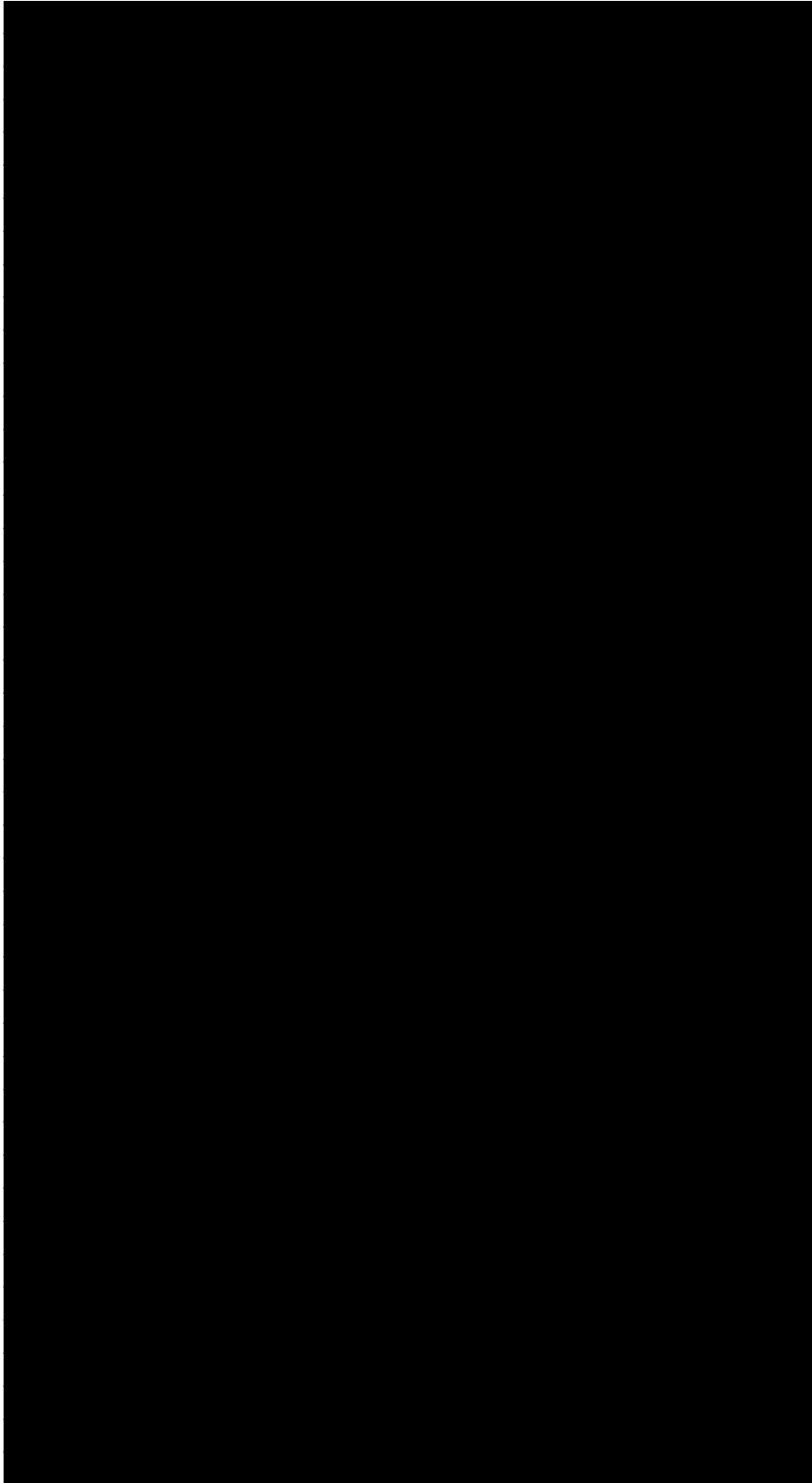
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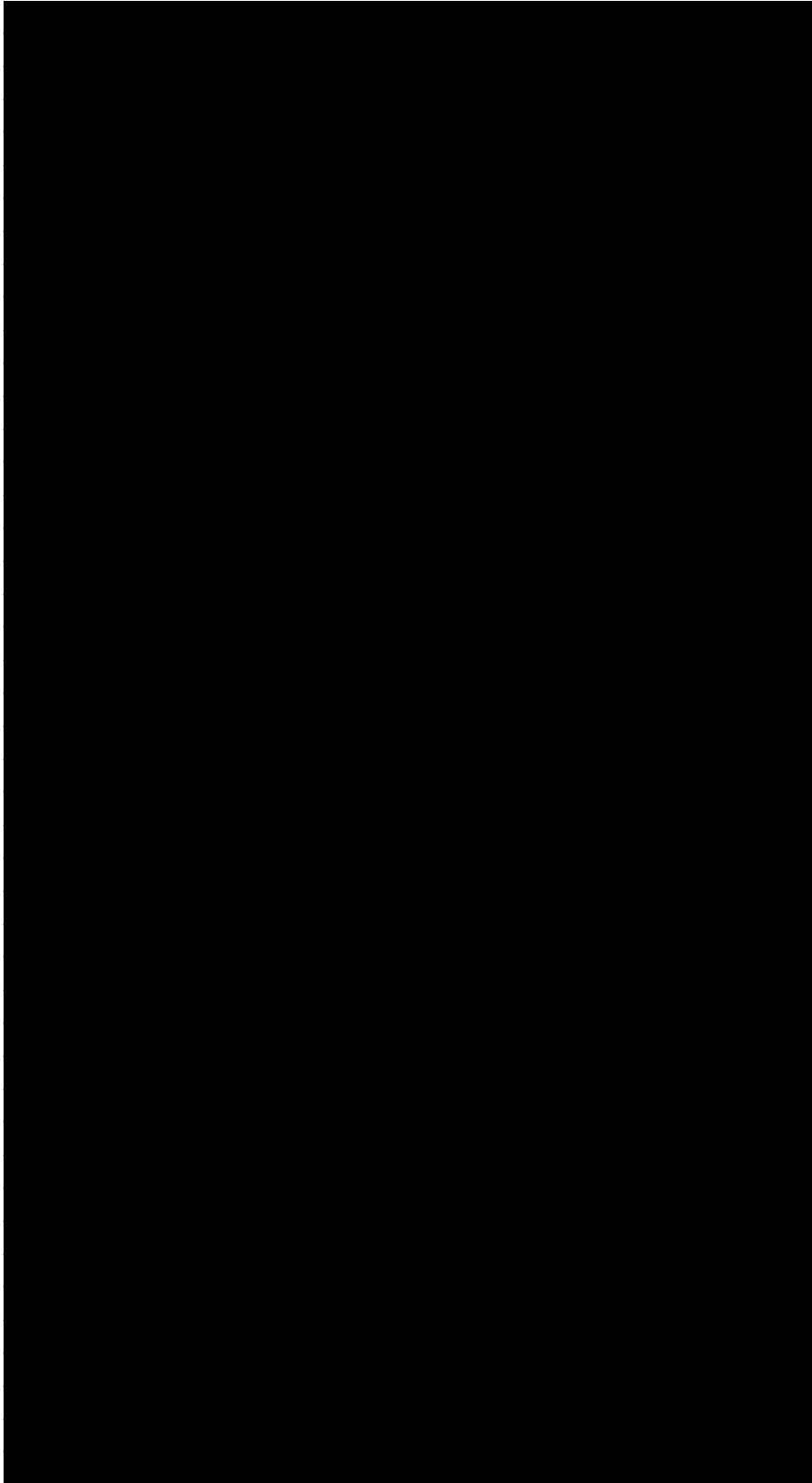
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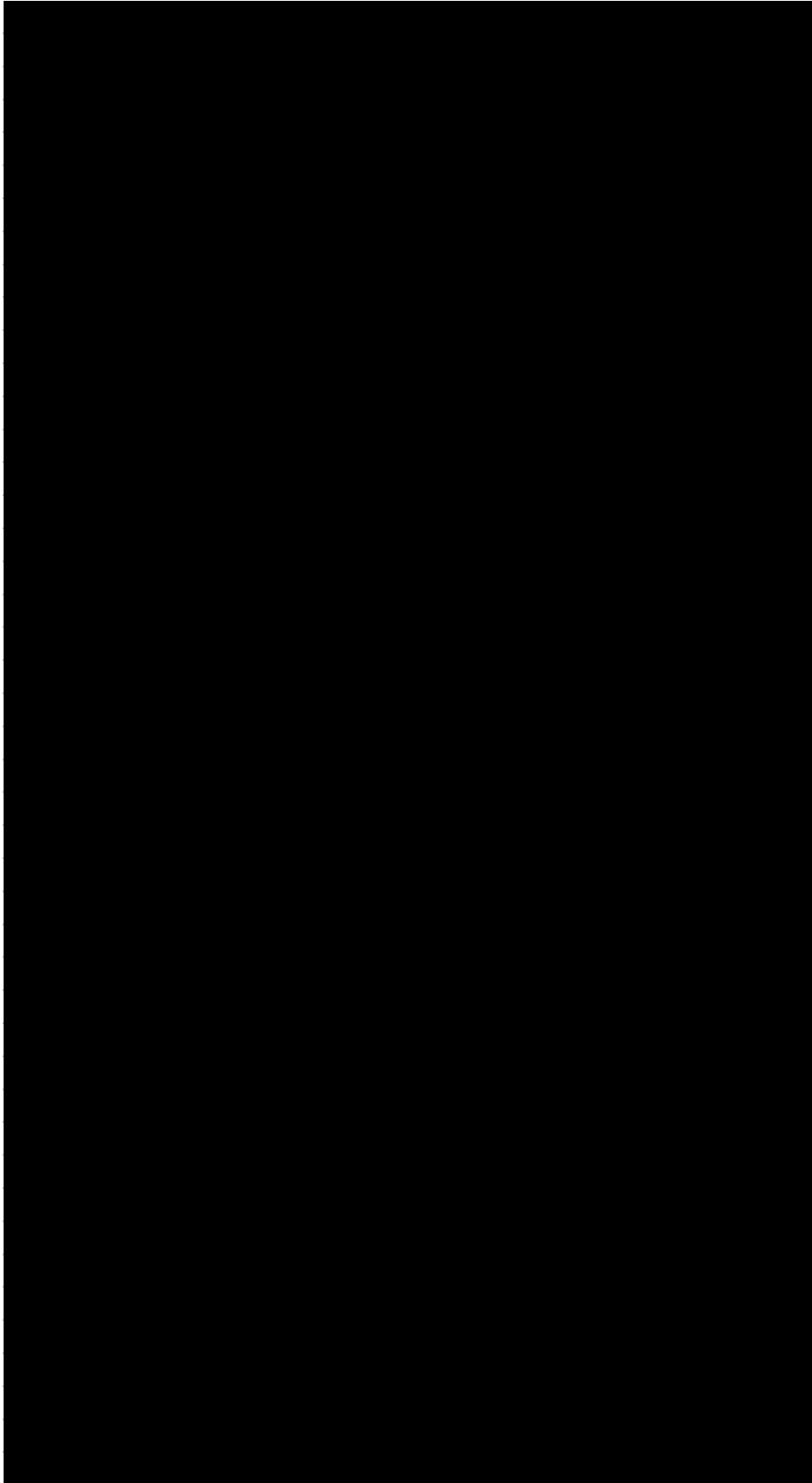


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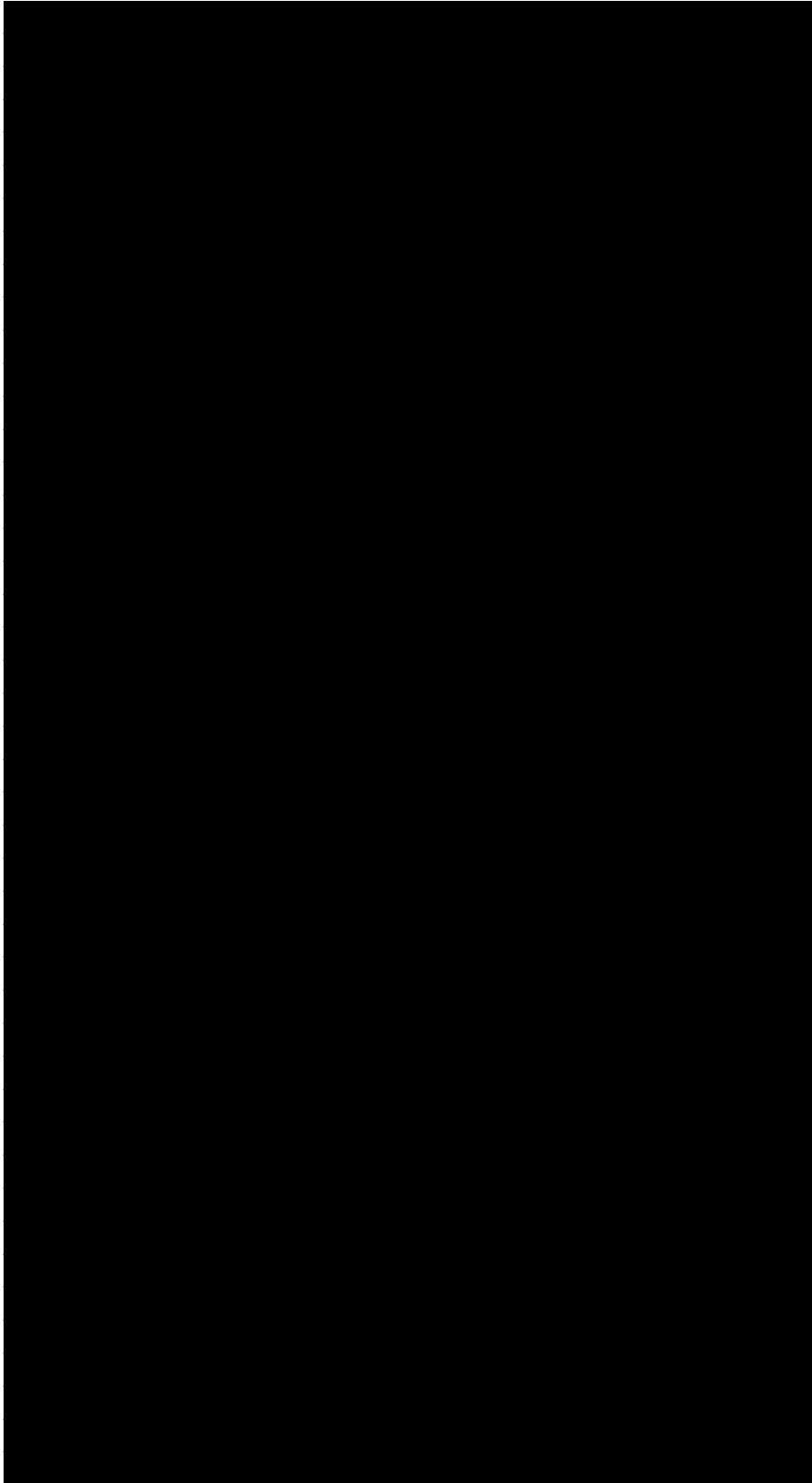


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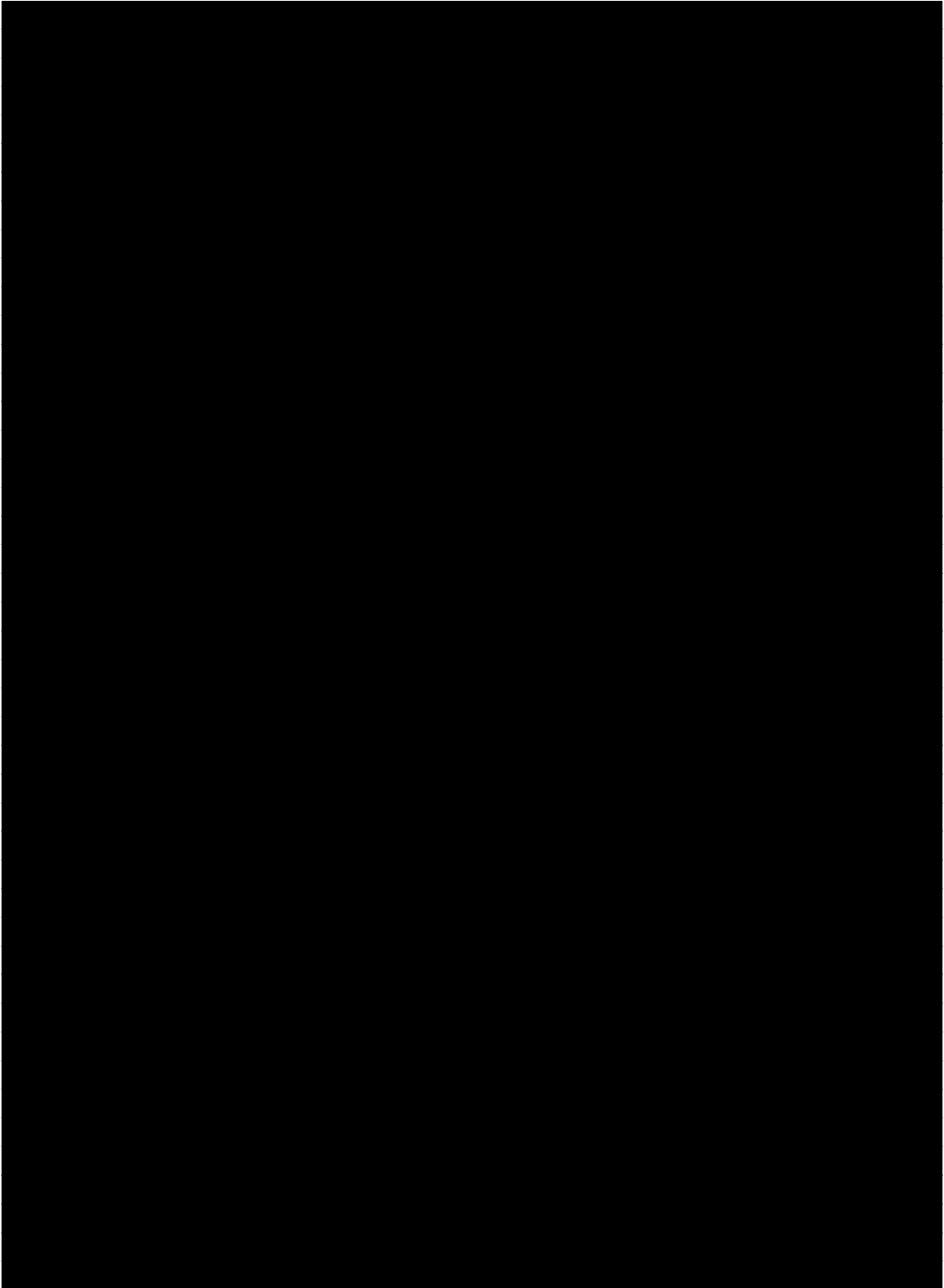
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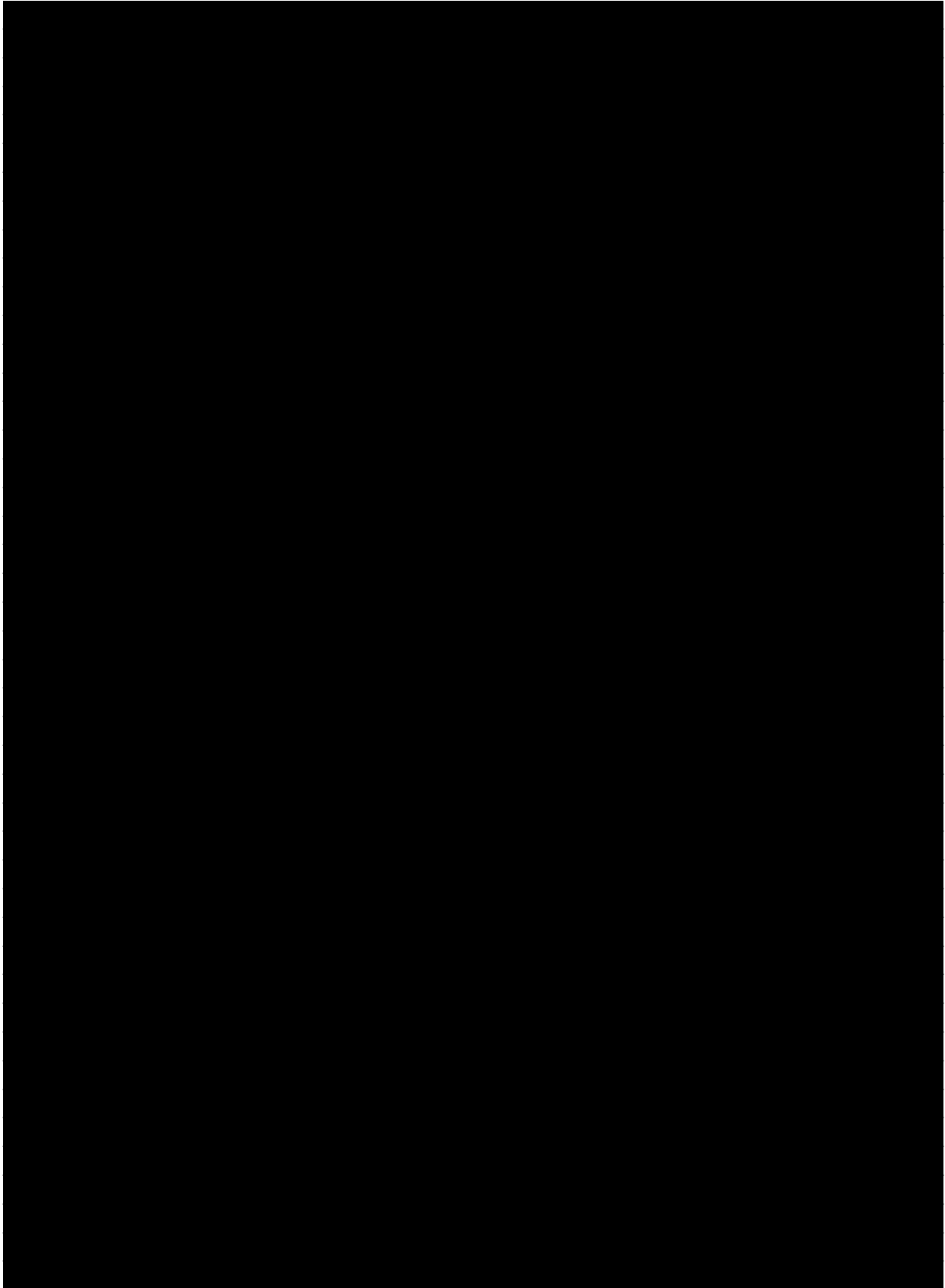
Section 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

Article 49 of the Public Health Law pertains to Utilization Review and External Appeal.

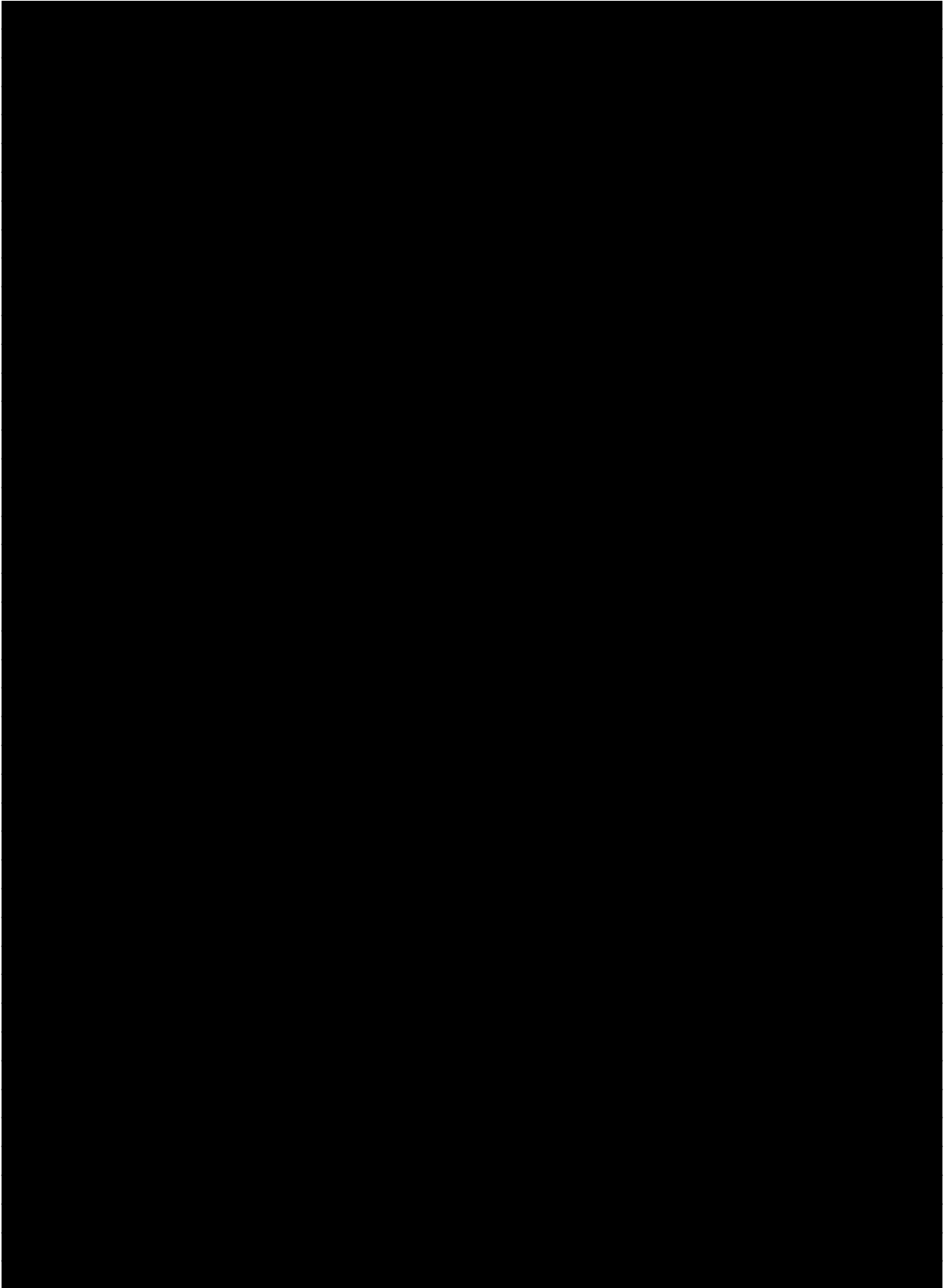
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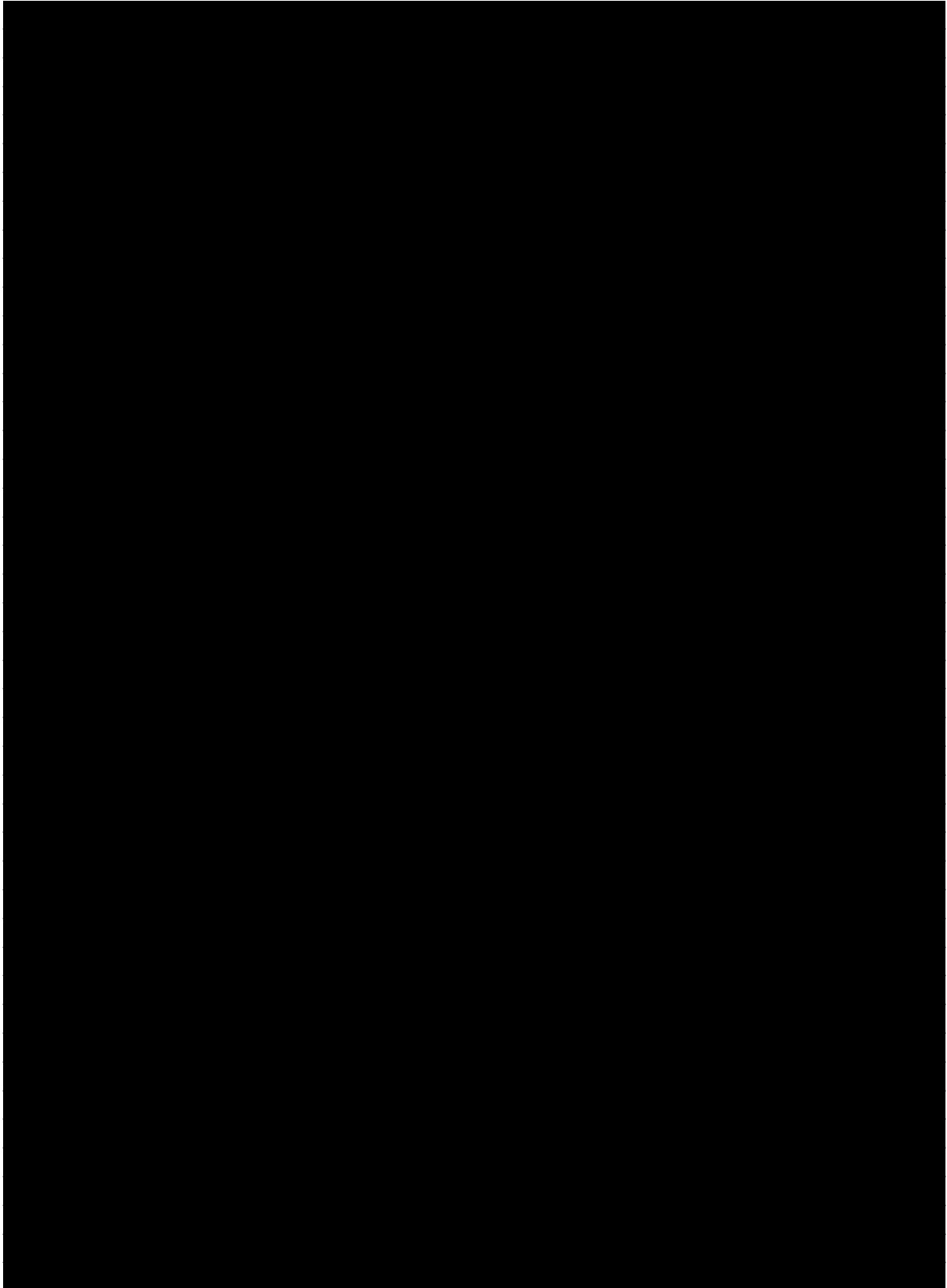
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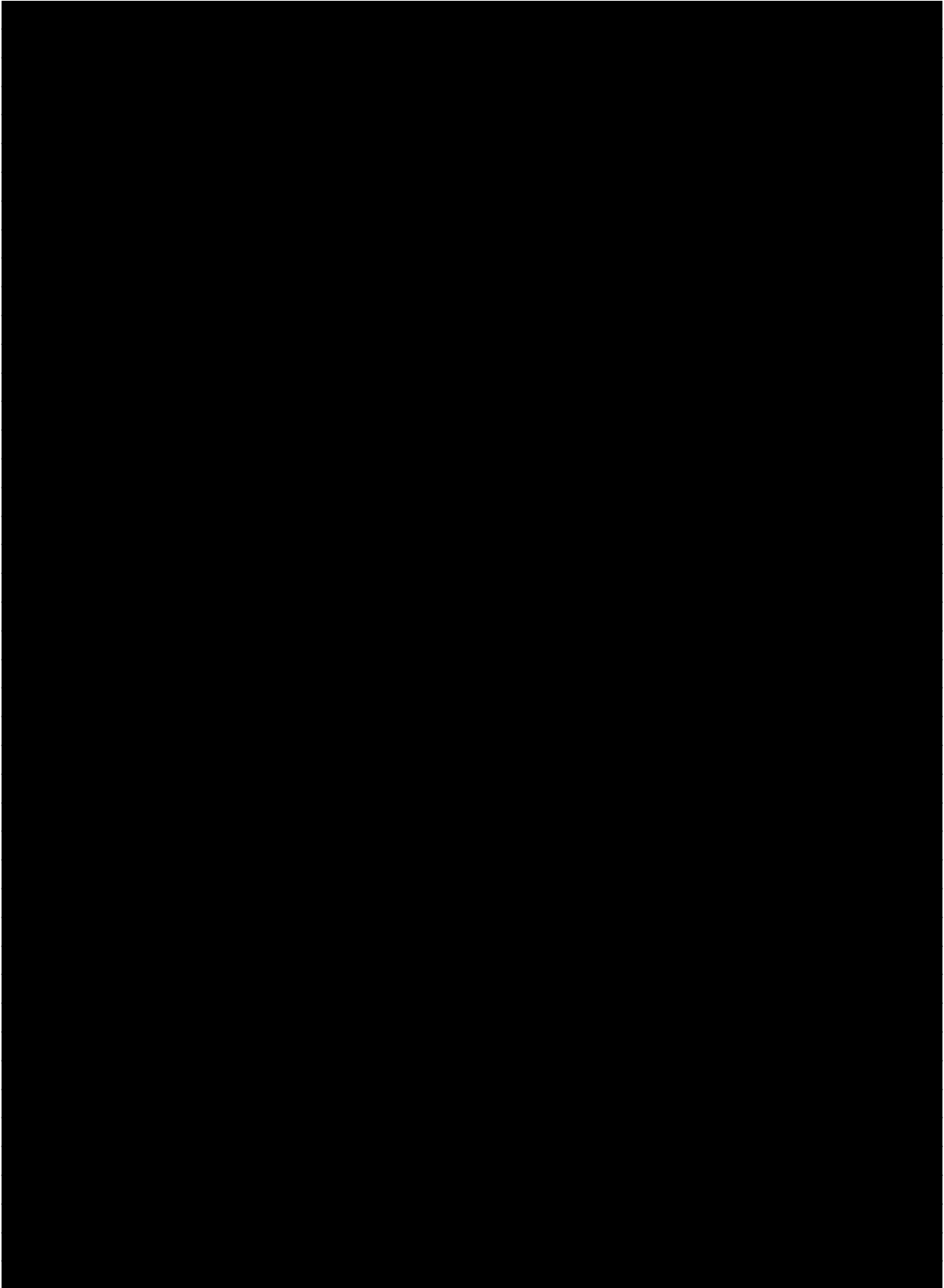


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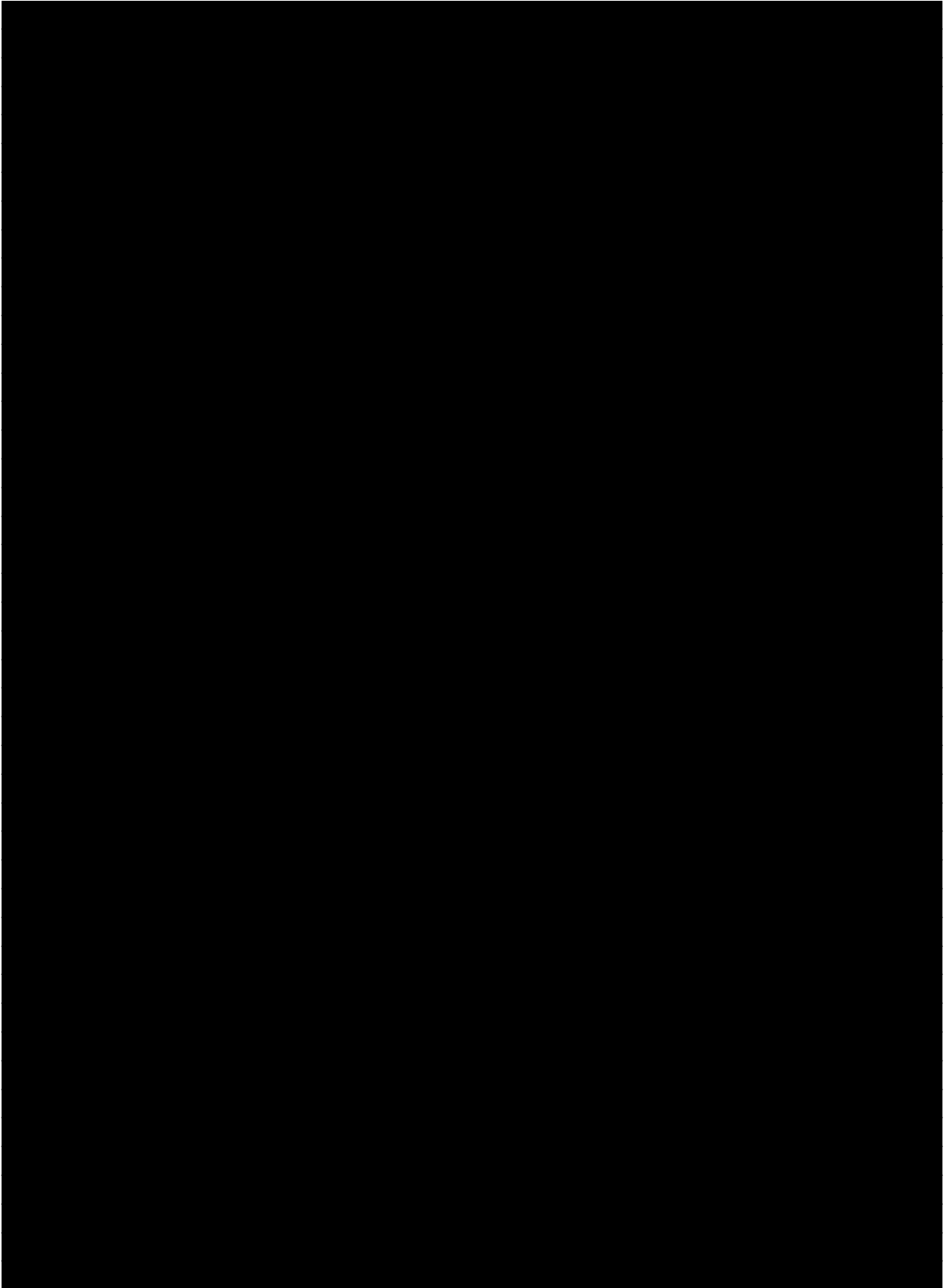




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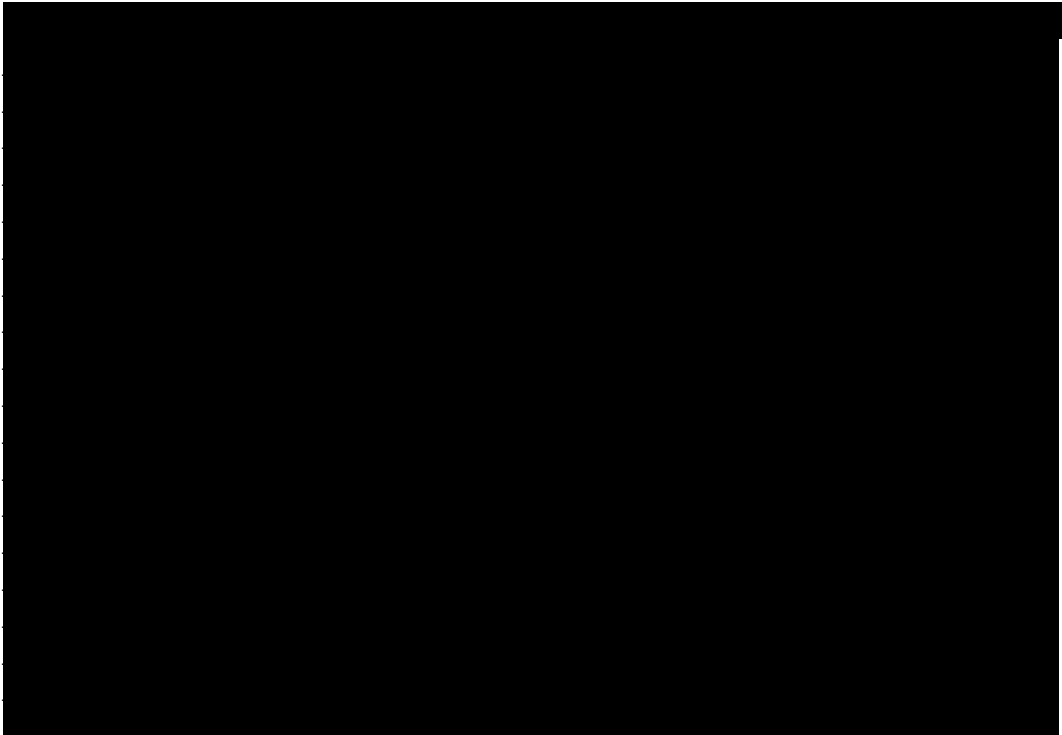
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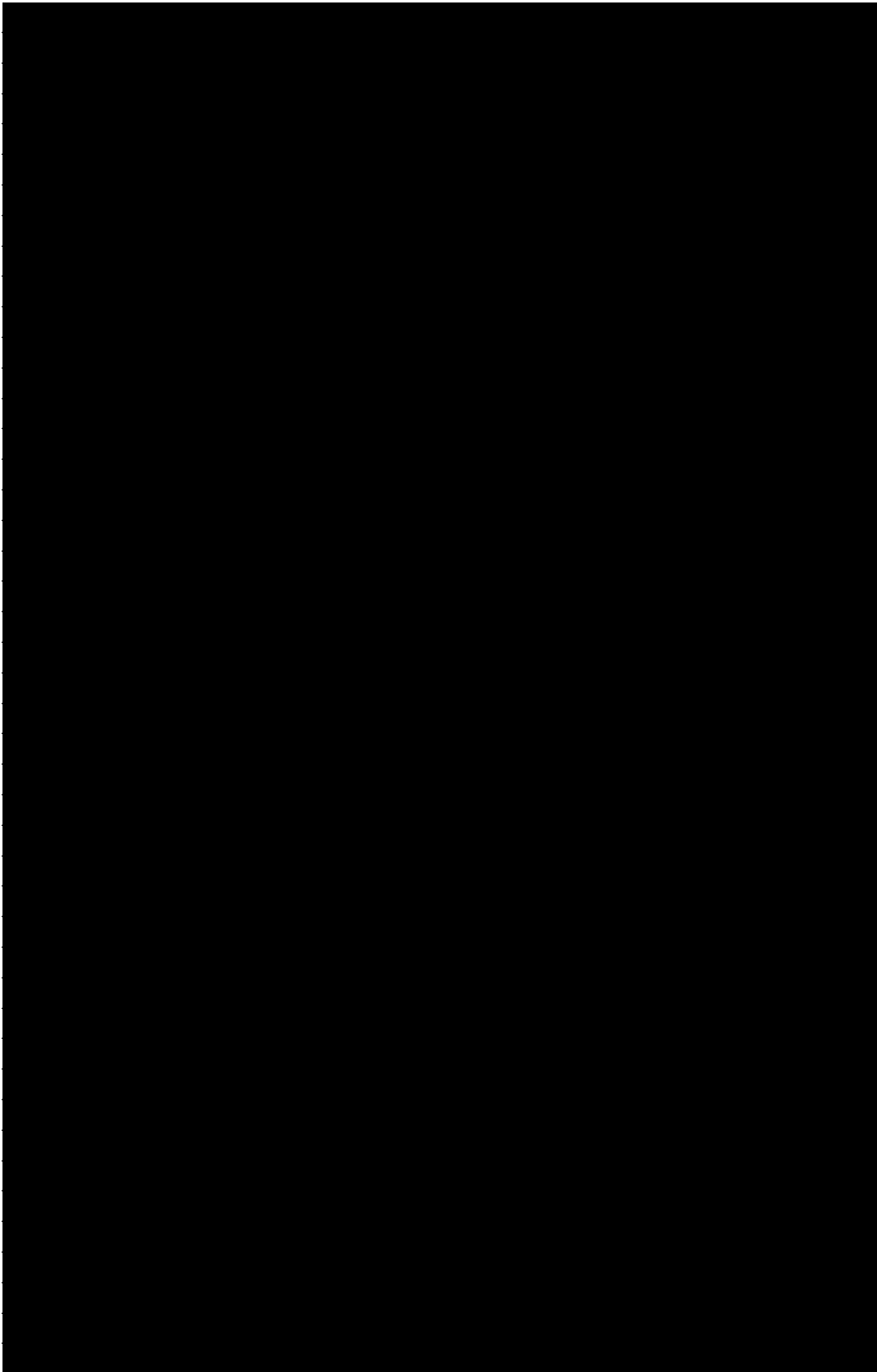


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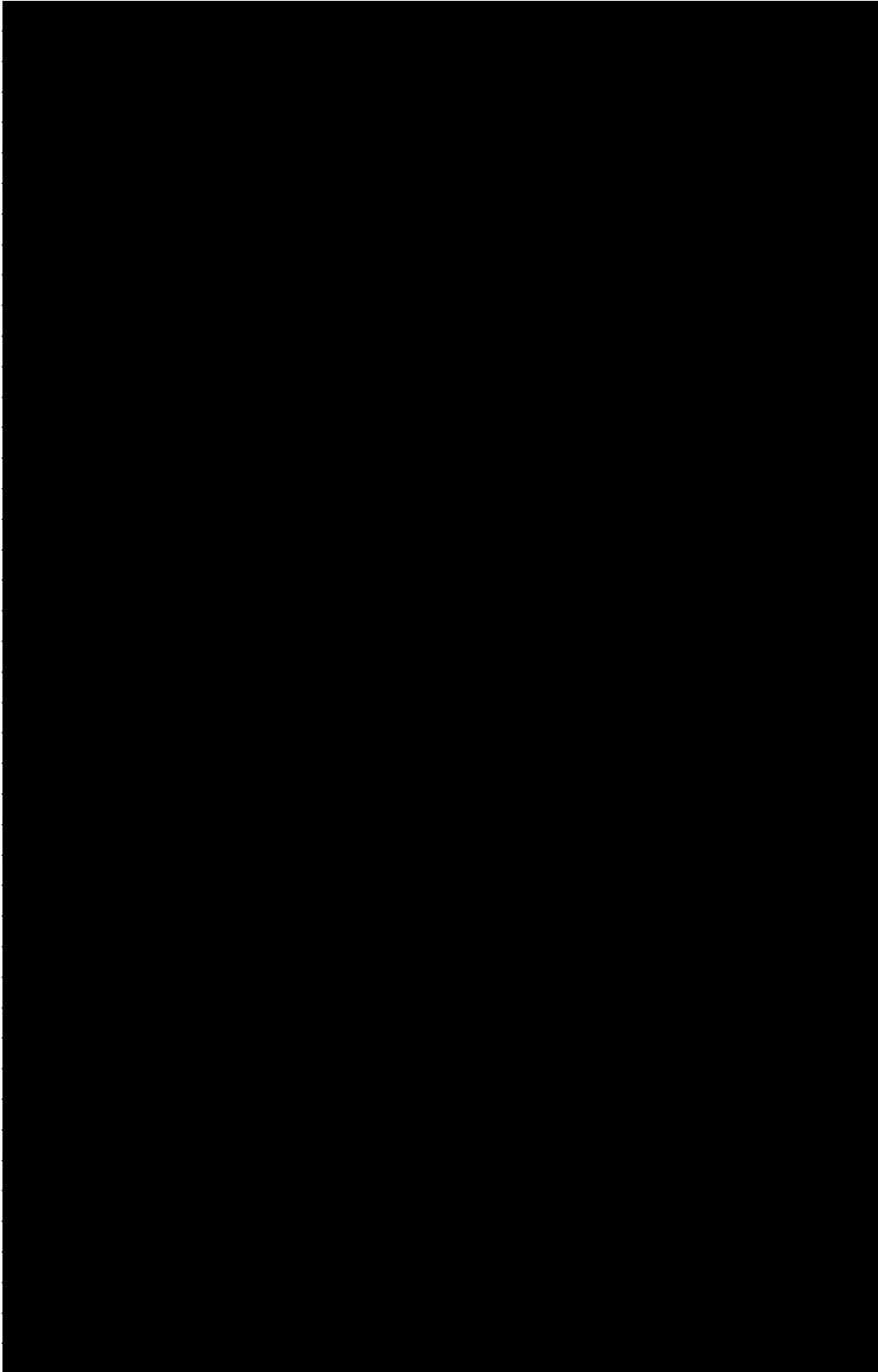


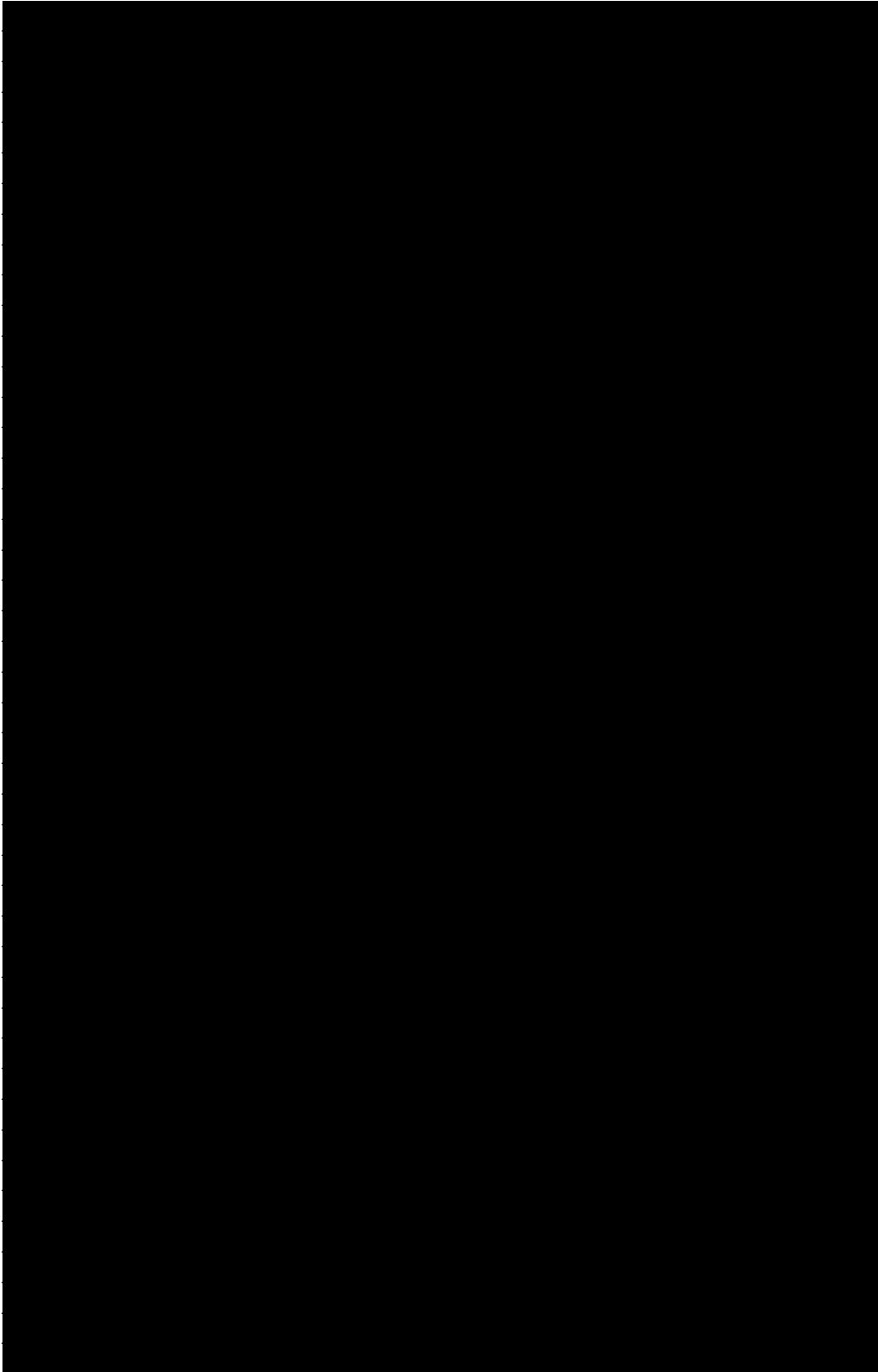
Section 505.14(a) of the Regulations provides:



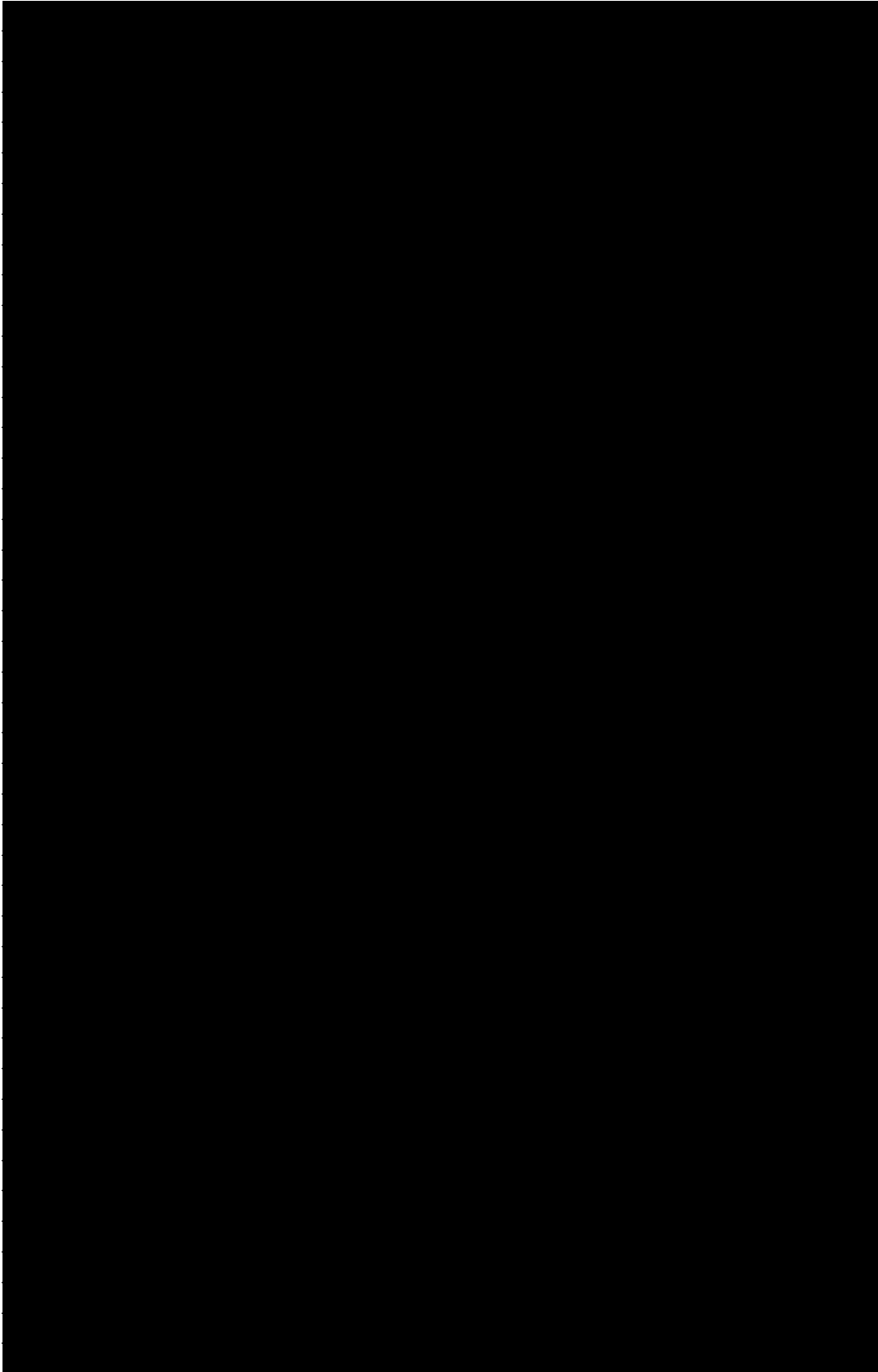


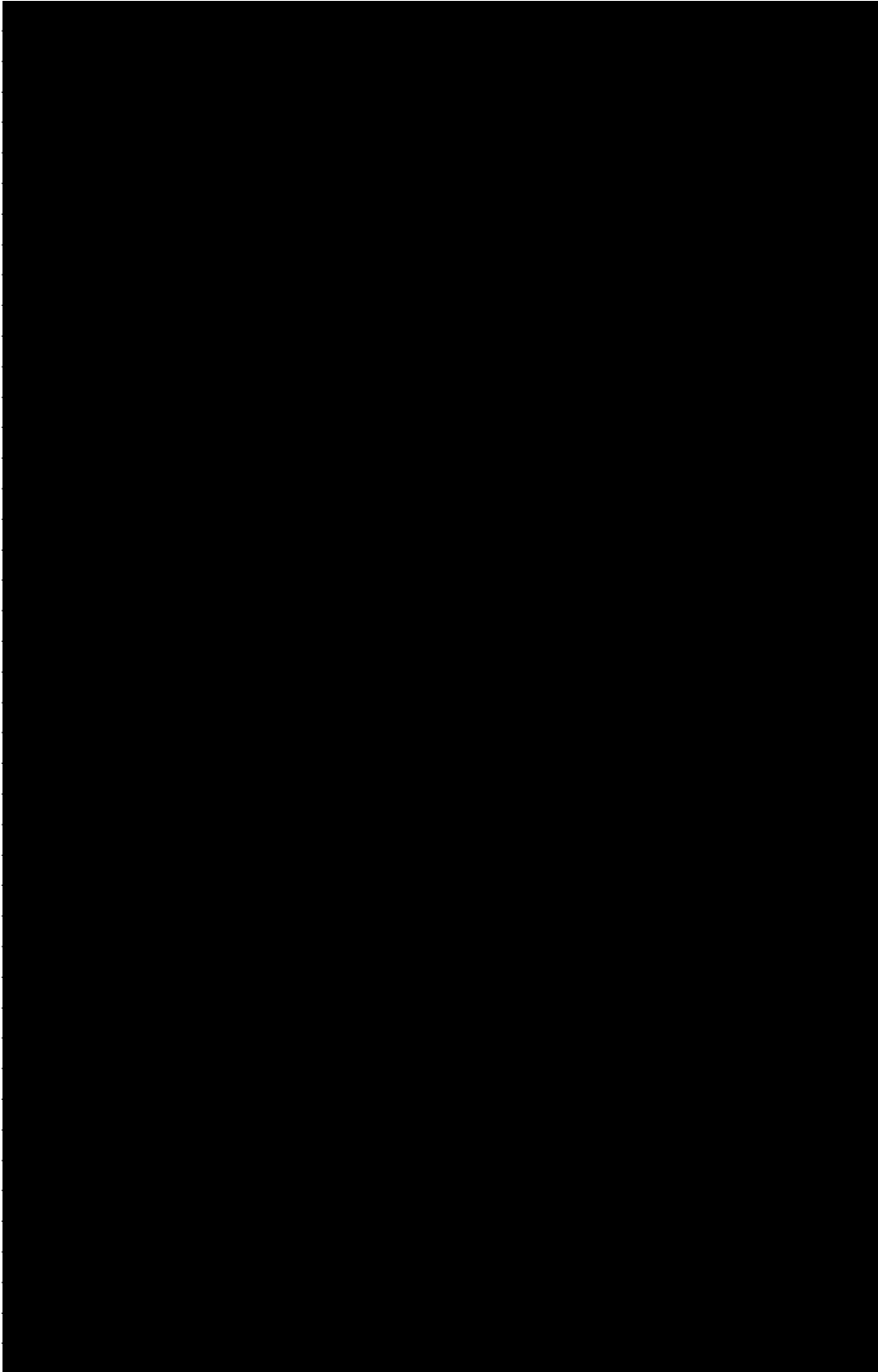
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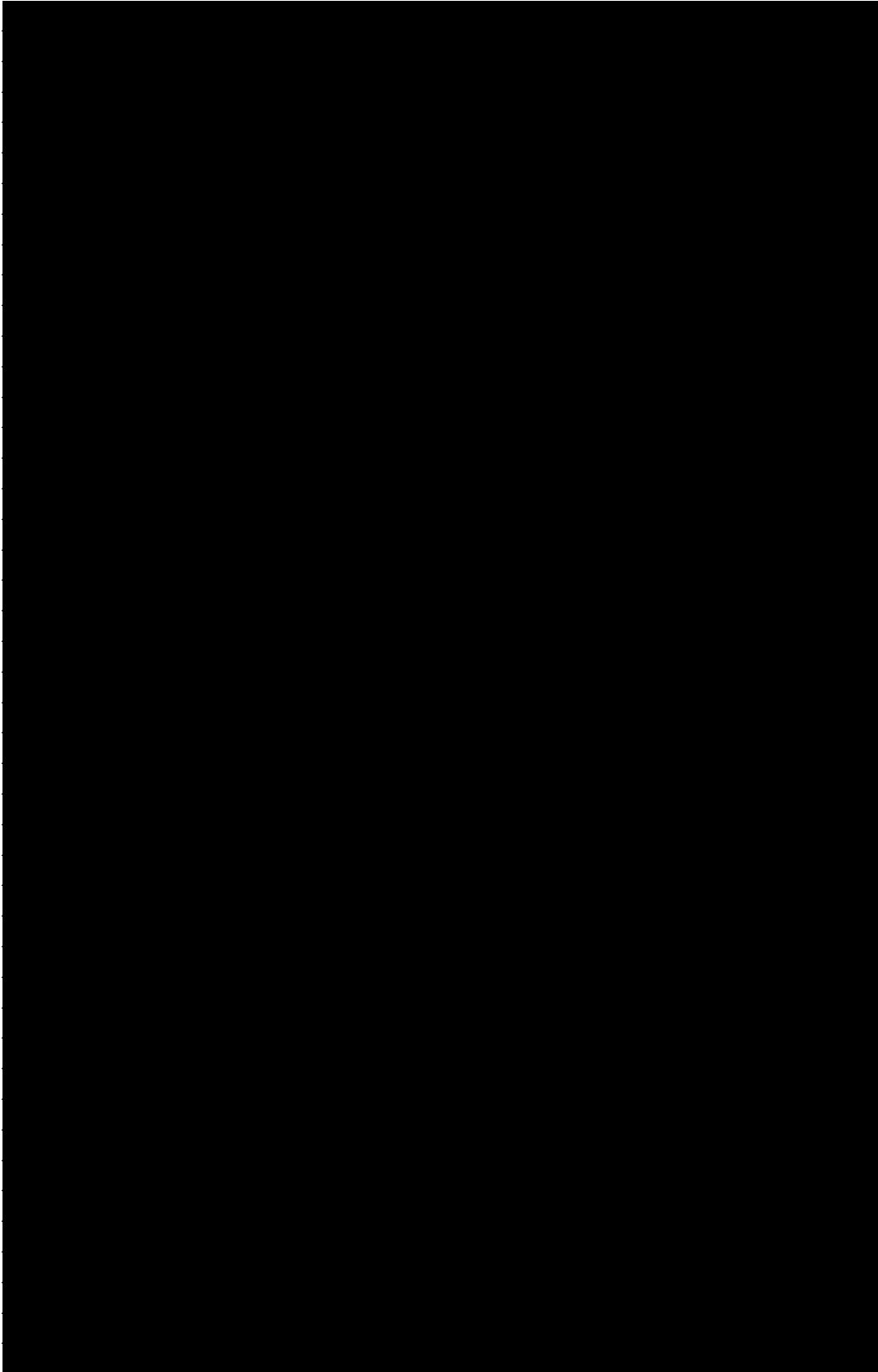


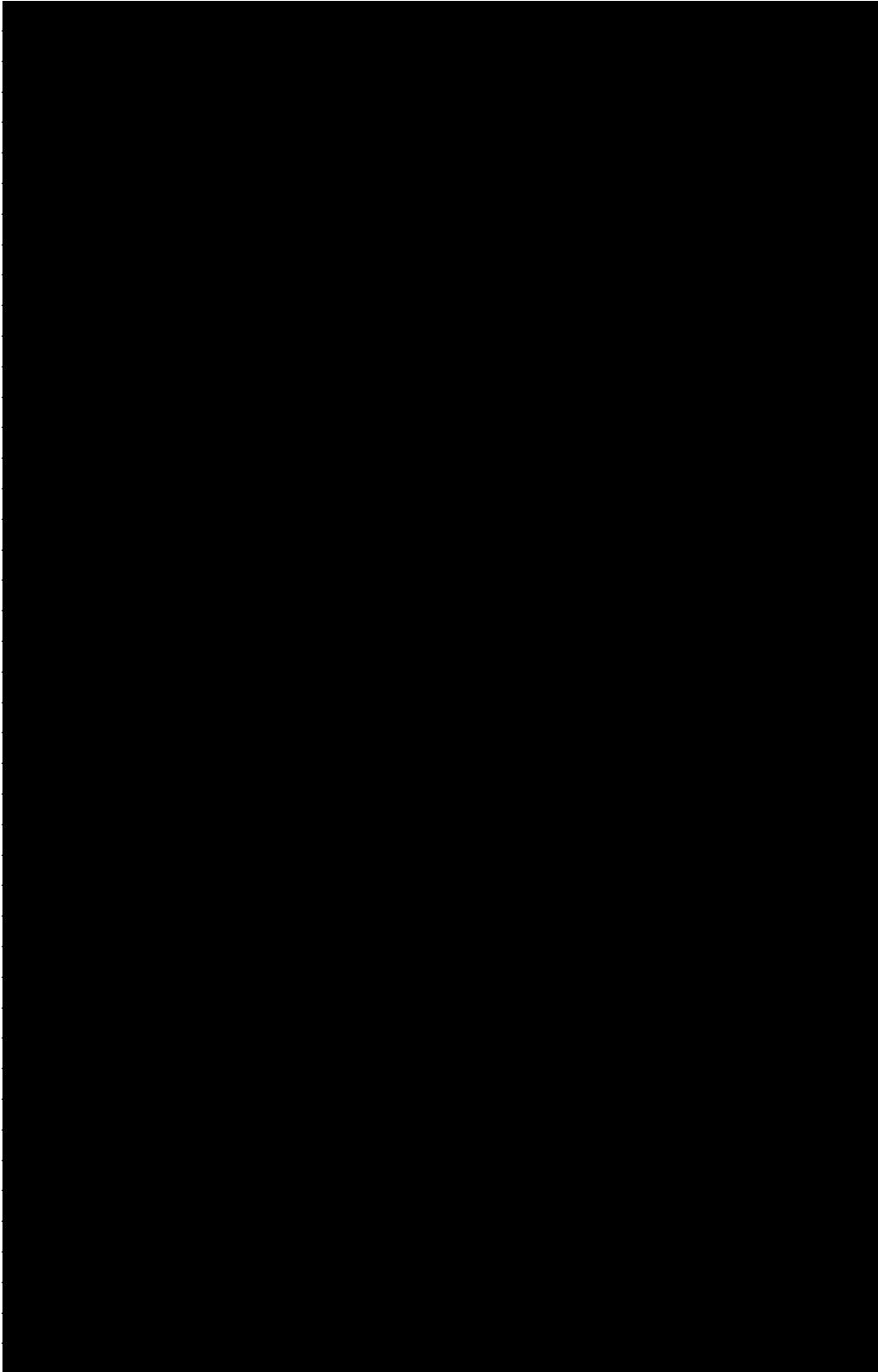
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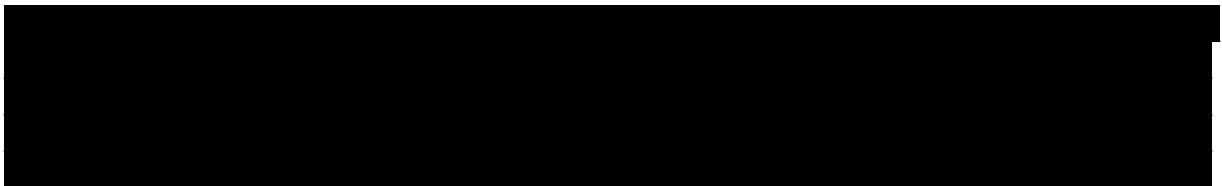
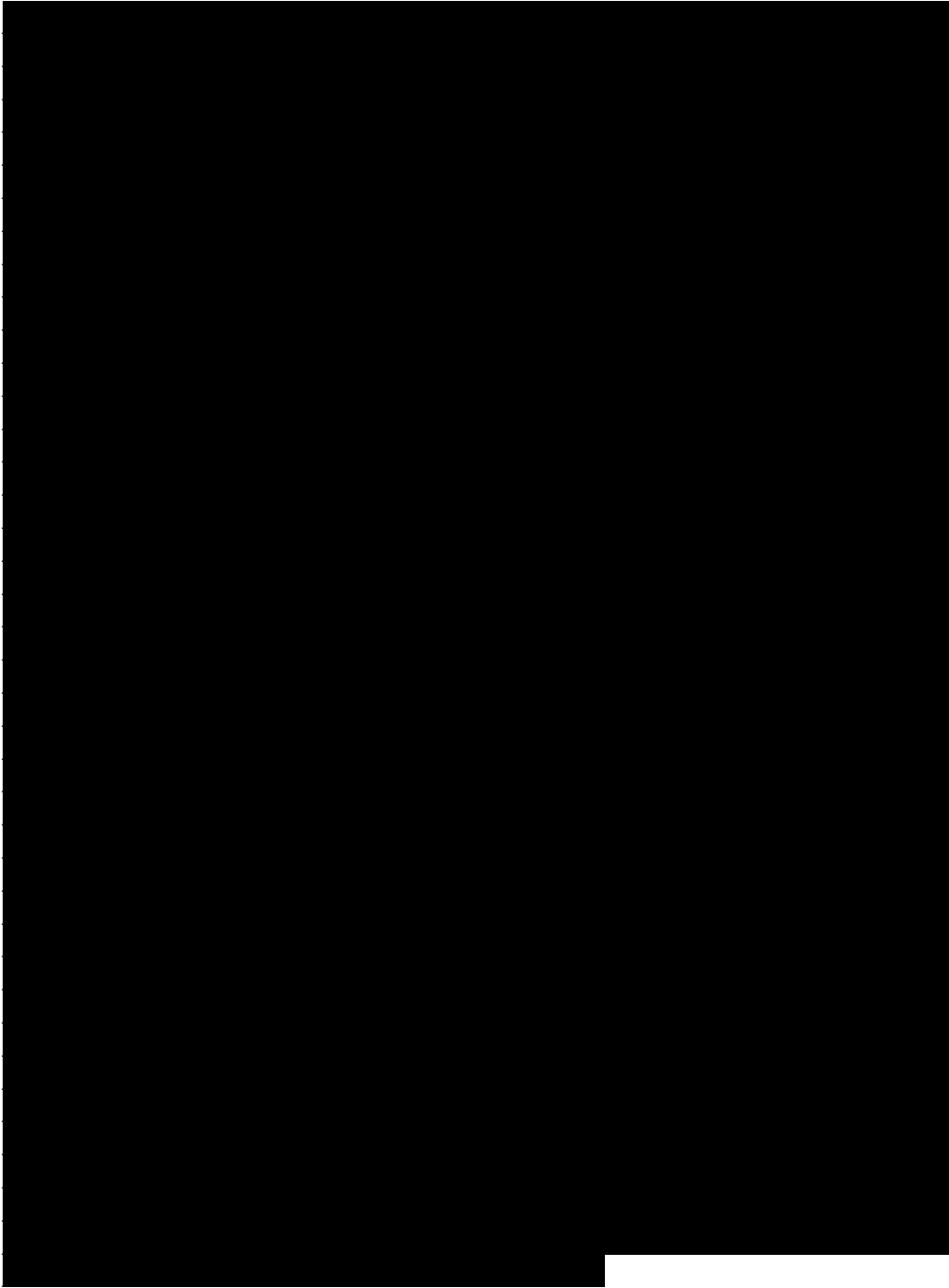


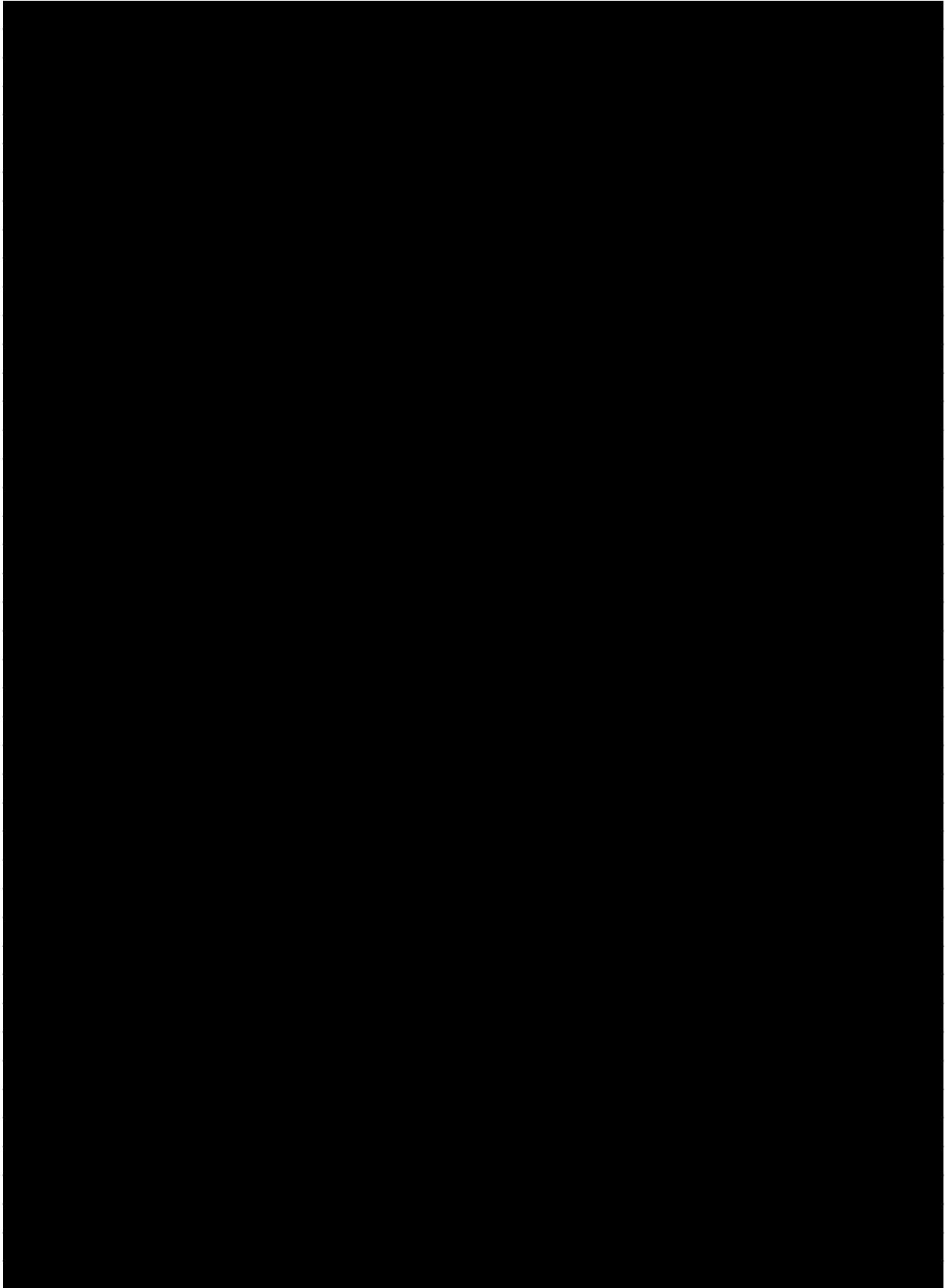
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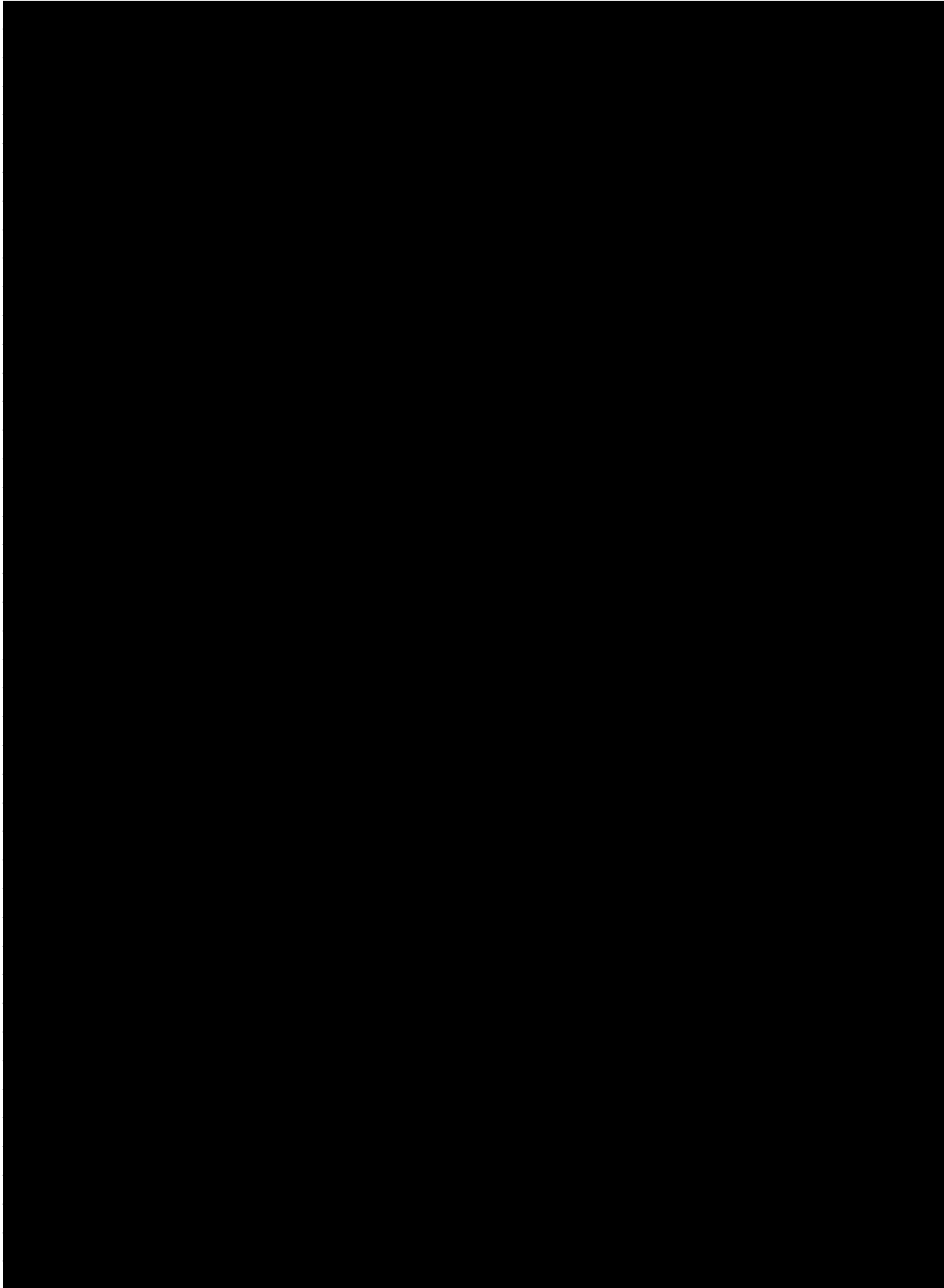


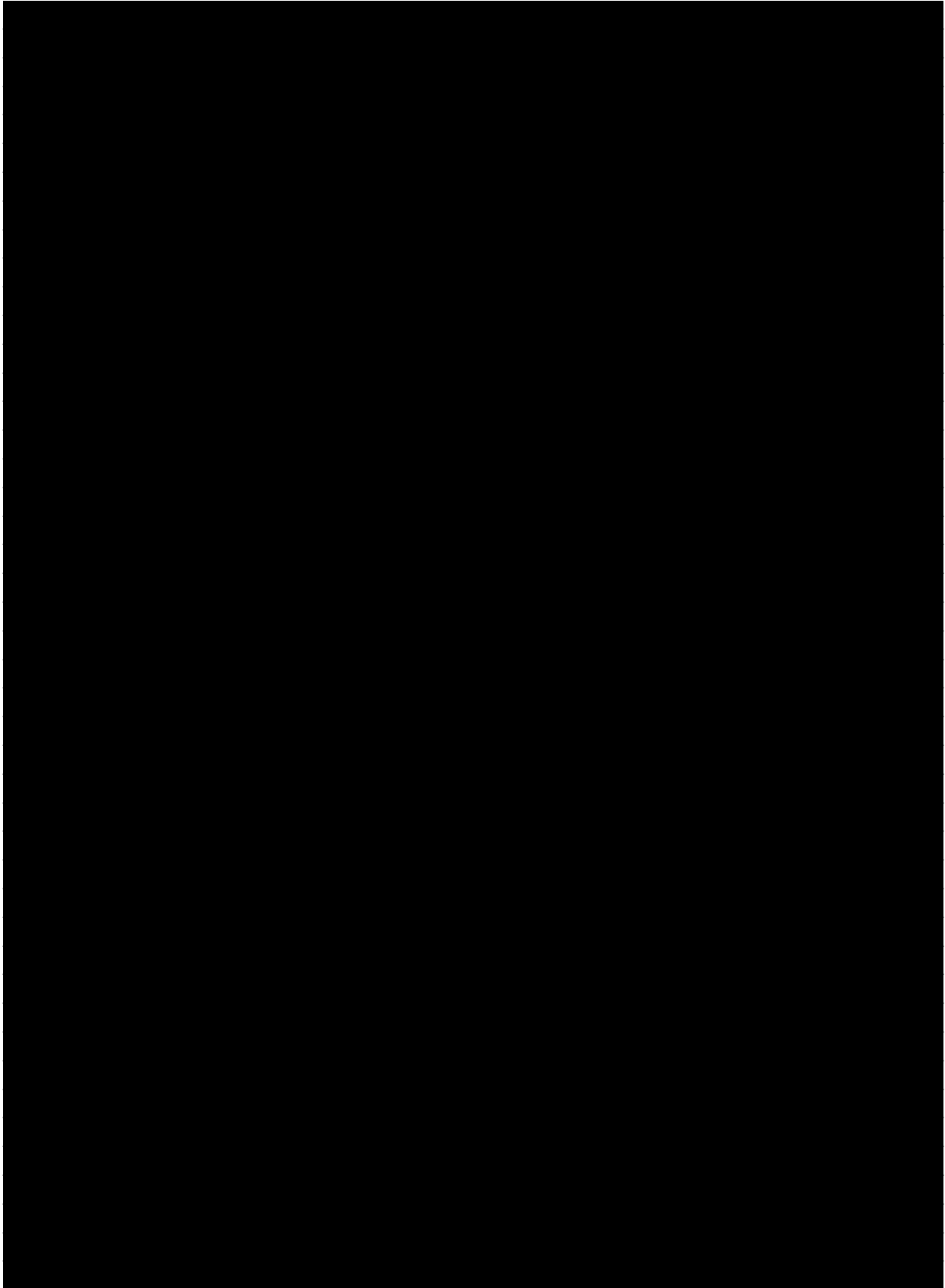


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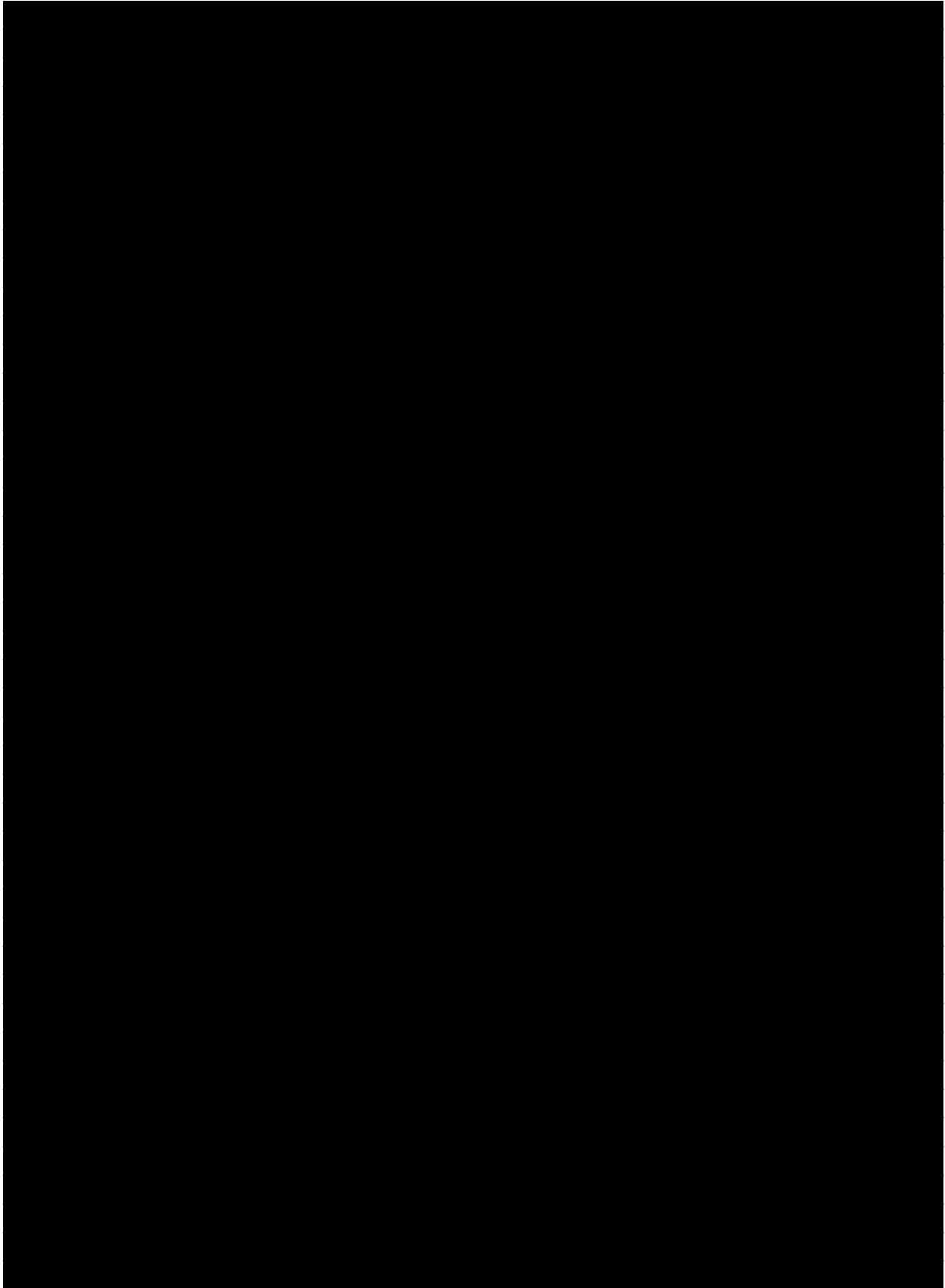


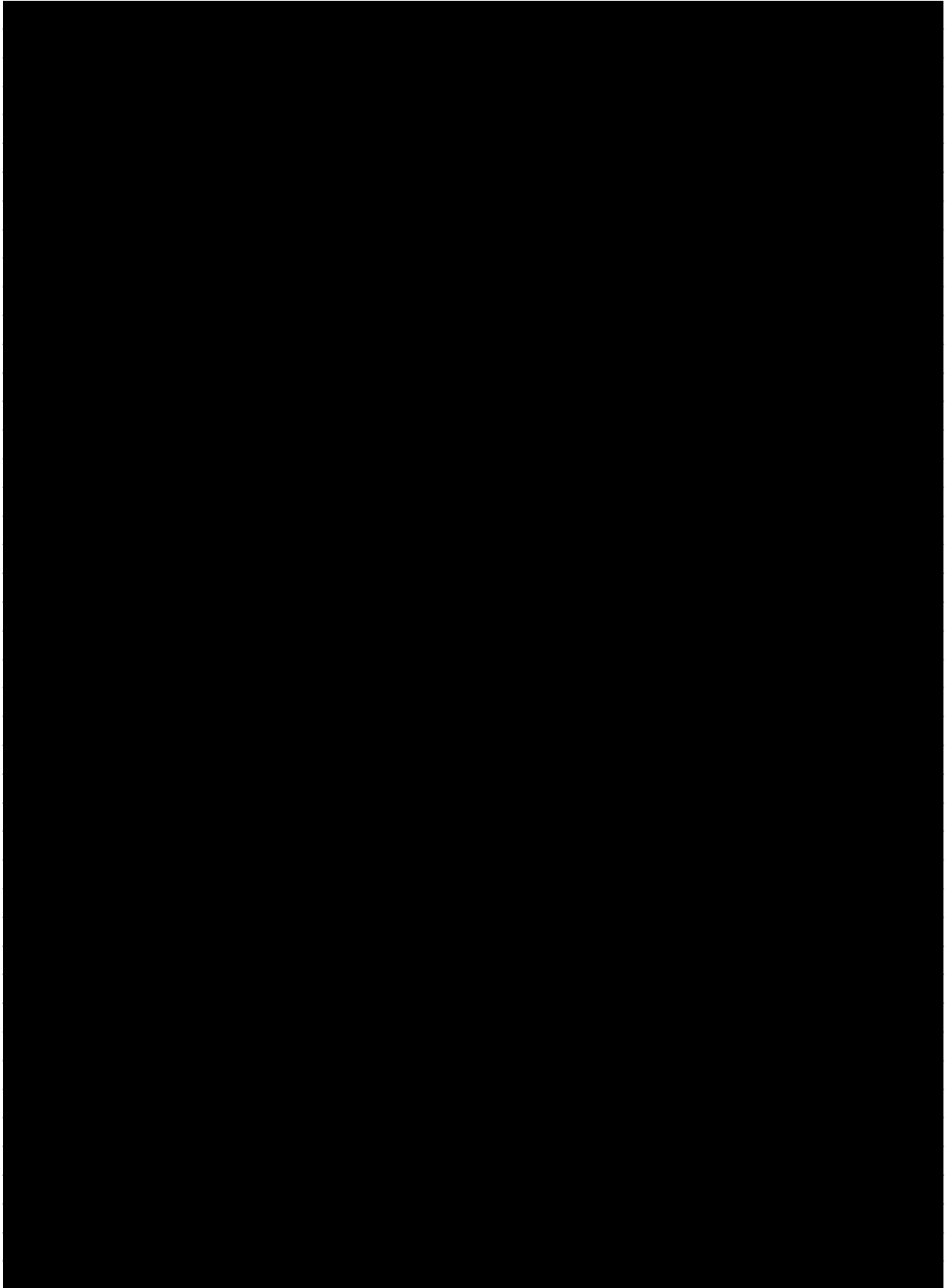




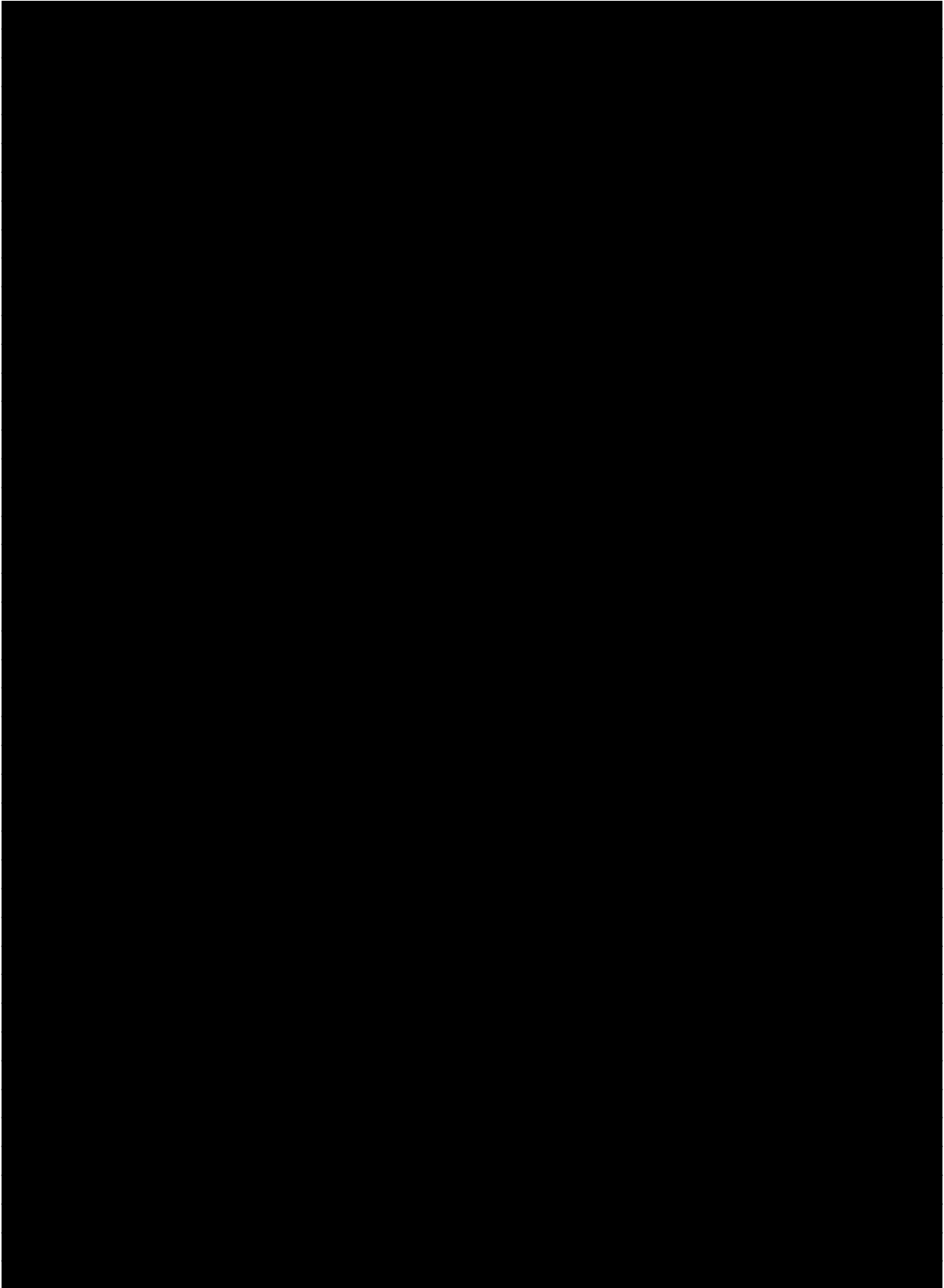


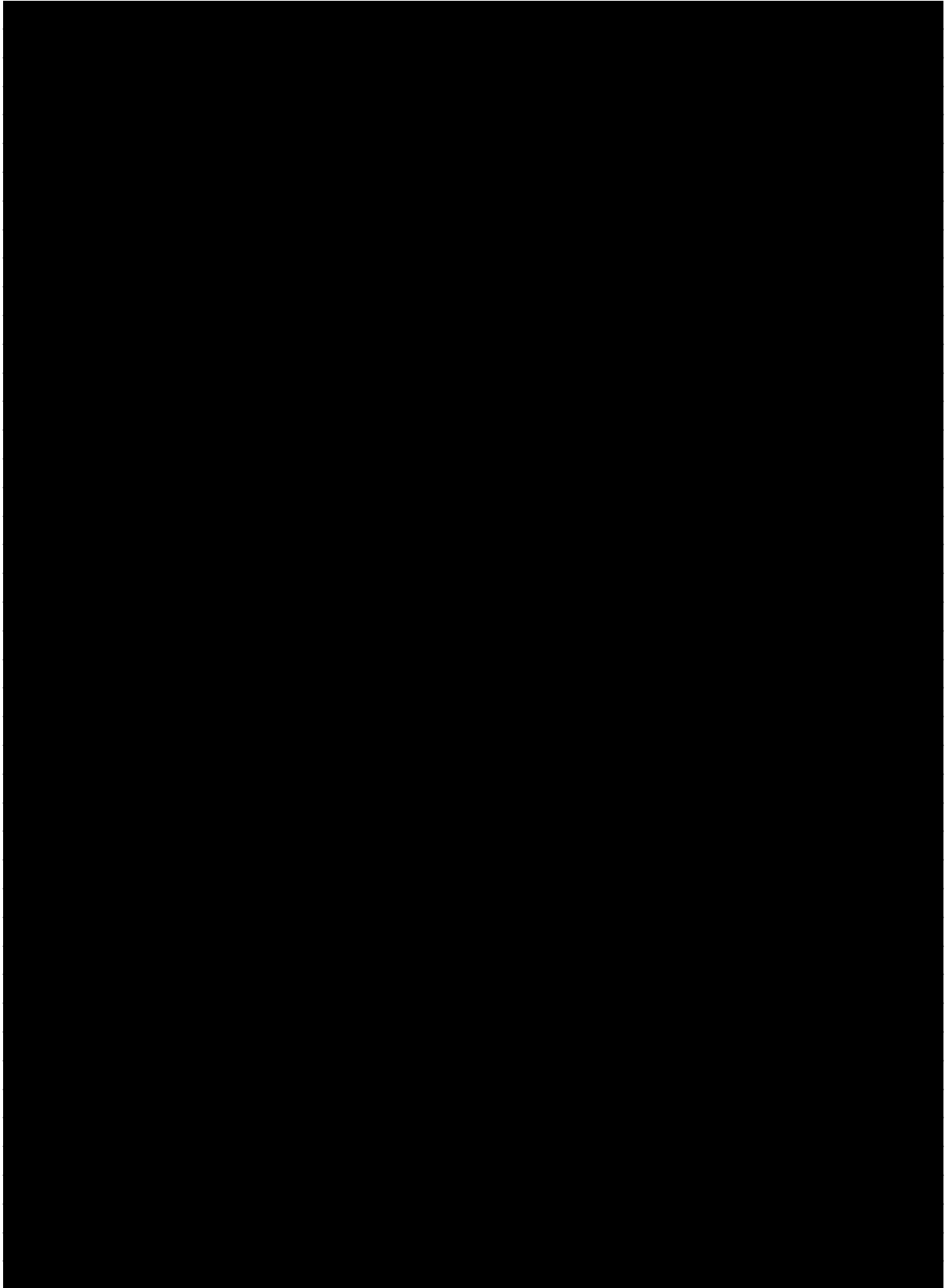
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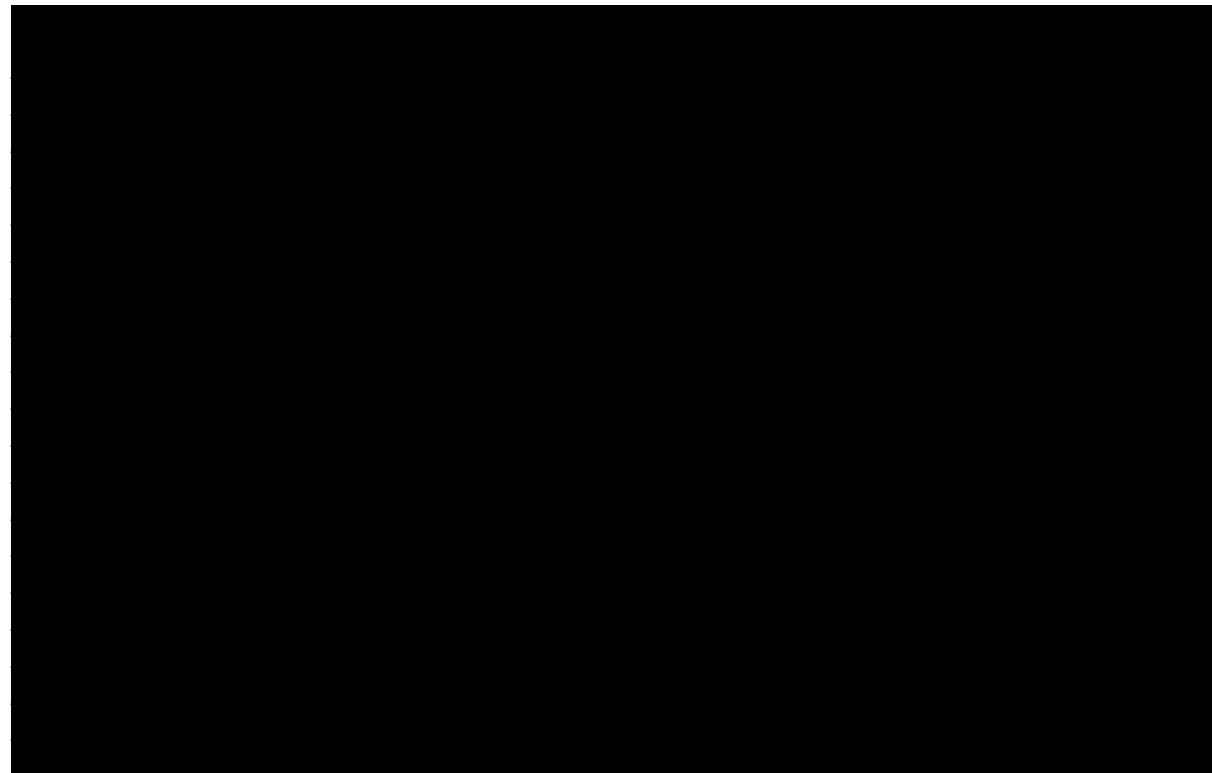


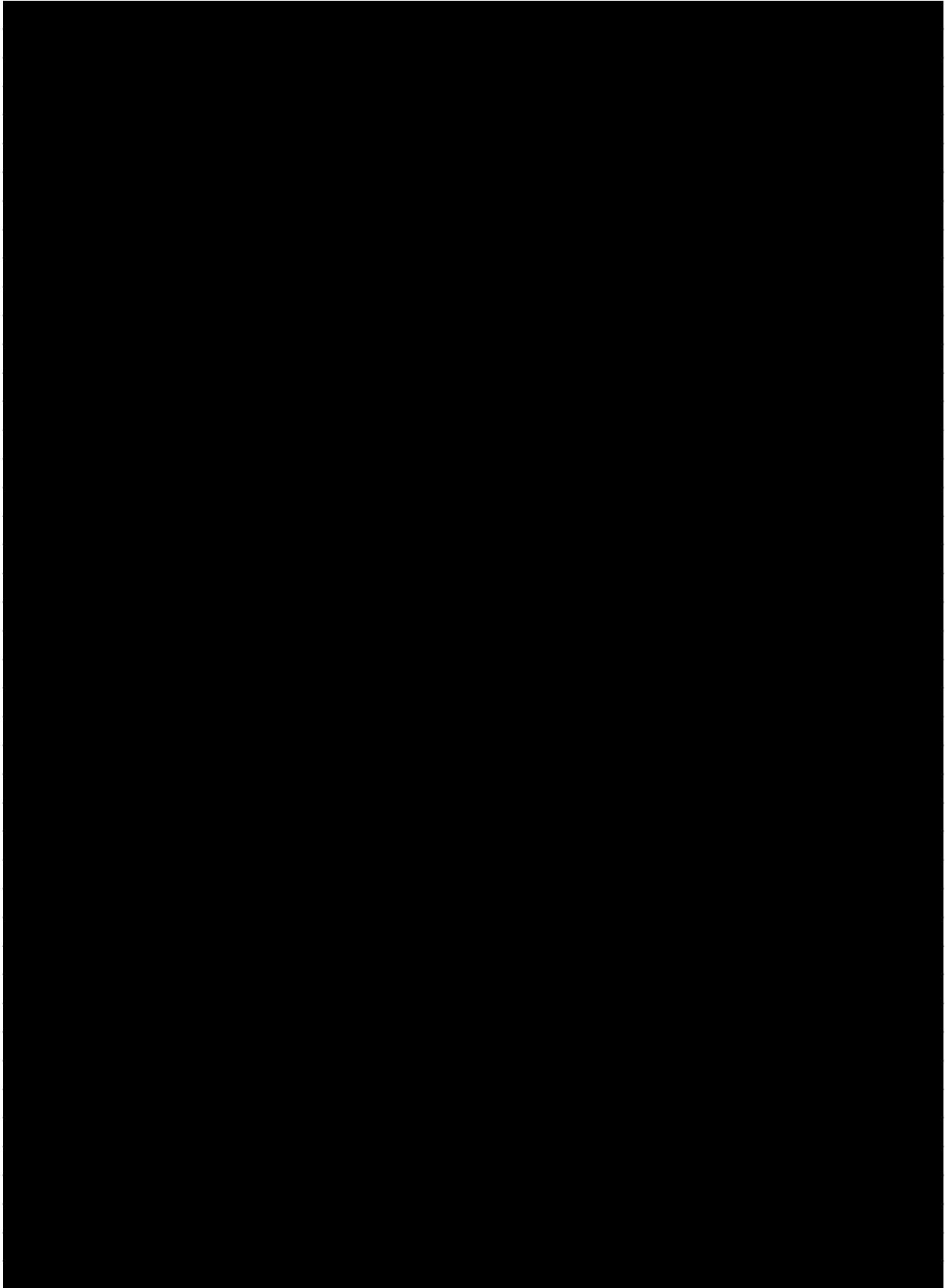


These changes to the PCS and CDPA regulations include, among other provisions, changes to the definitions and eligibility requirements for continuous (“split-shift”) PCS and CDPA as well as live-in 24-hour PCS and CDPA. Consequently, MLTCPs must be aware of, and apply, effective immediately, the revised definitions and eligibility requirements when conducting PCA and CDPA assessments and reassessments. In addition, the revised regulations set forth revised criteria for notices that deny, reduce or discontinue these services. See the attached detailed summary of these changes and the Notice of Adoption, as published in the New York State Register on December 23, 2015.

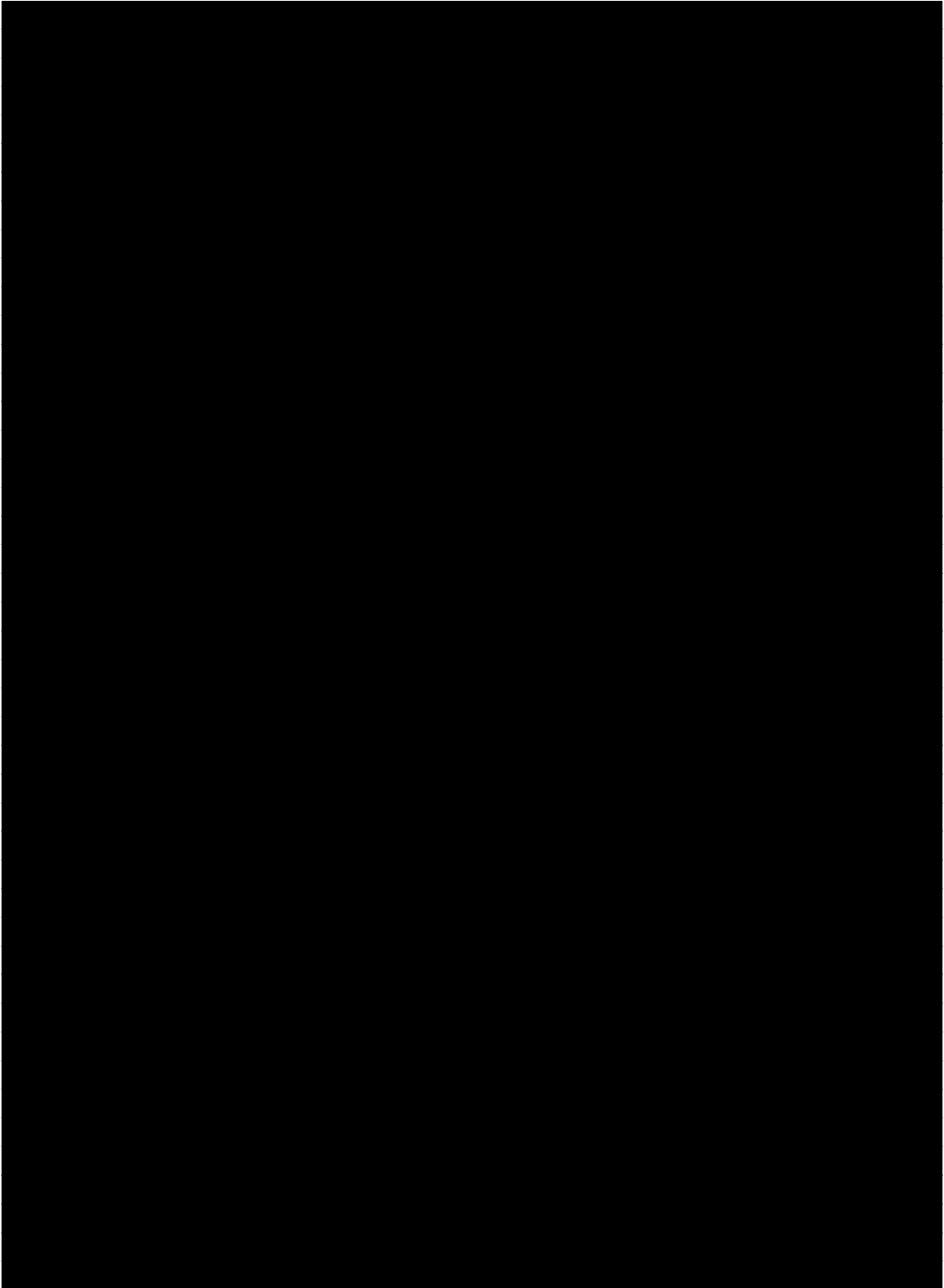
Regulatory changes for PCS and CDPA applicable to MLTCP’s include:

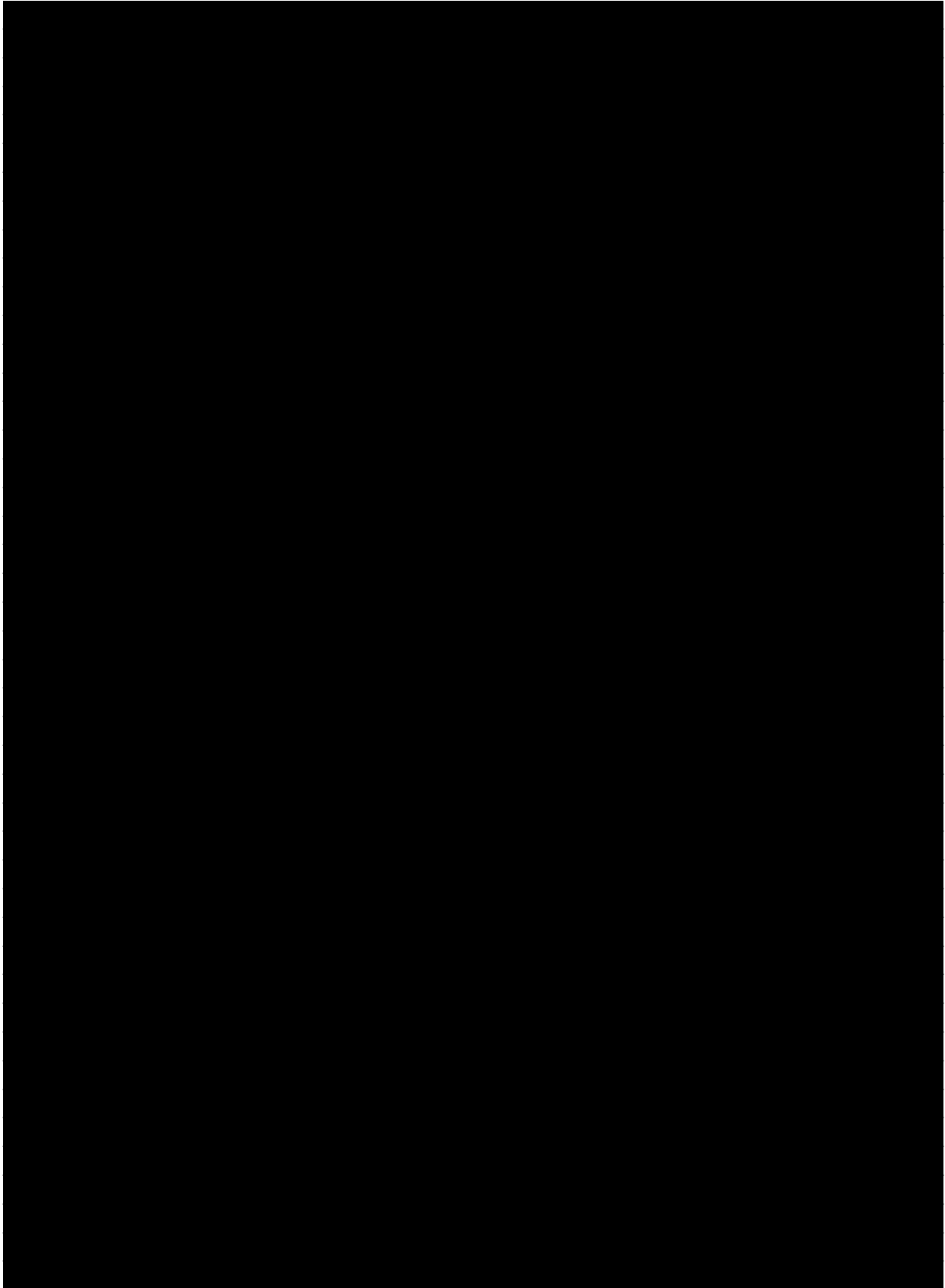
1. The definitions of “some assistance” and “total assistance” are repealed in their entirety. This means, in part, that a “total assistance” need with certain activities of per day living is no longer an eligibility requirement for continuous personal care services or continuous consumer directed personal assistance.

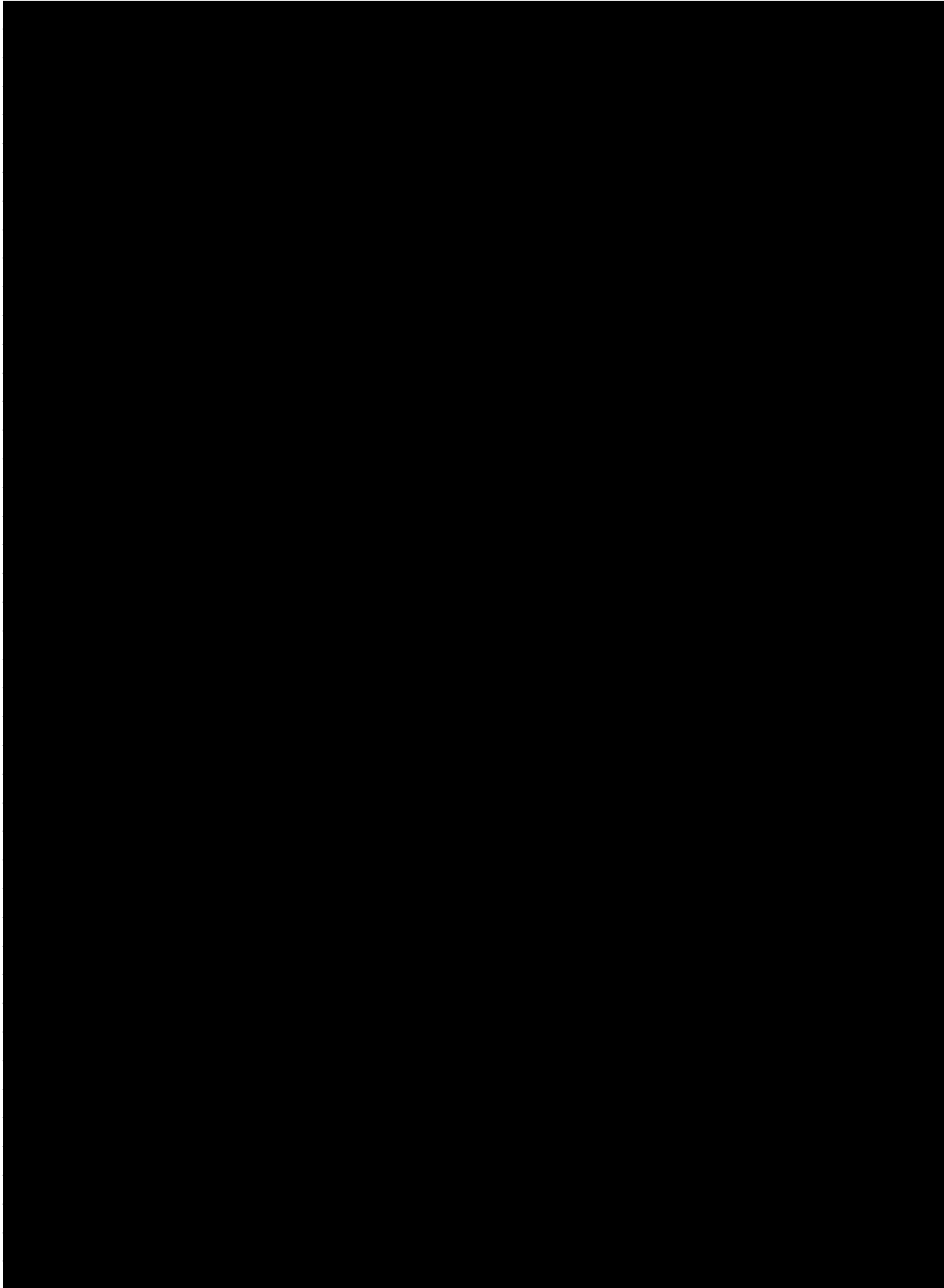


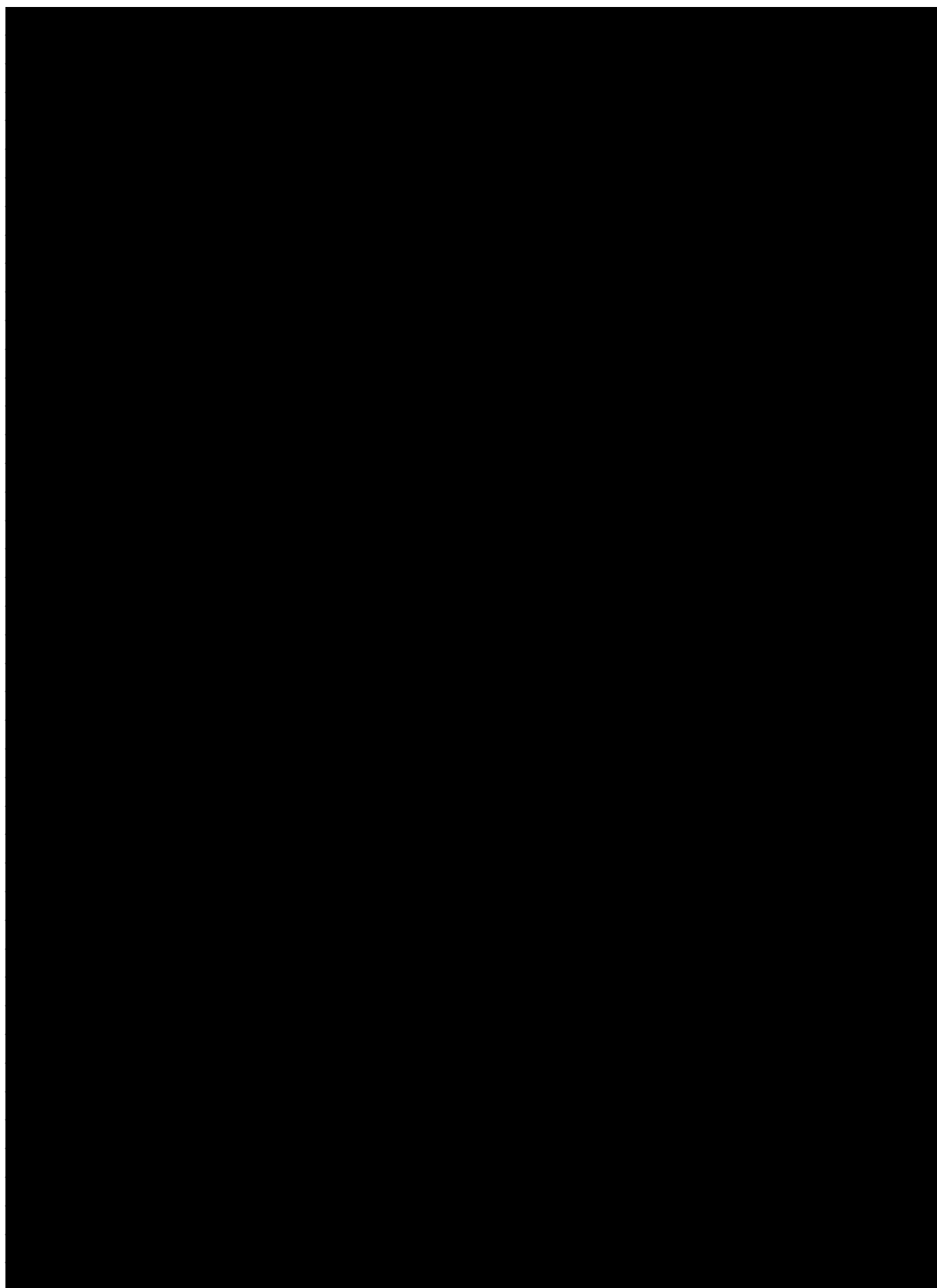


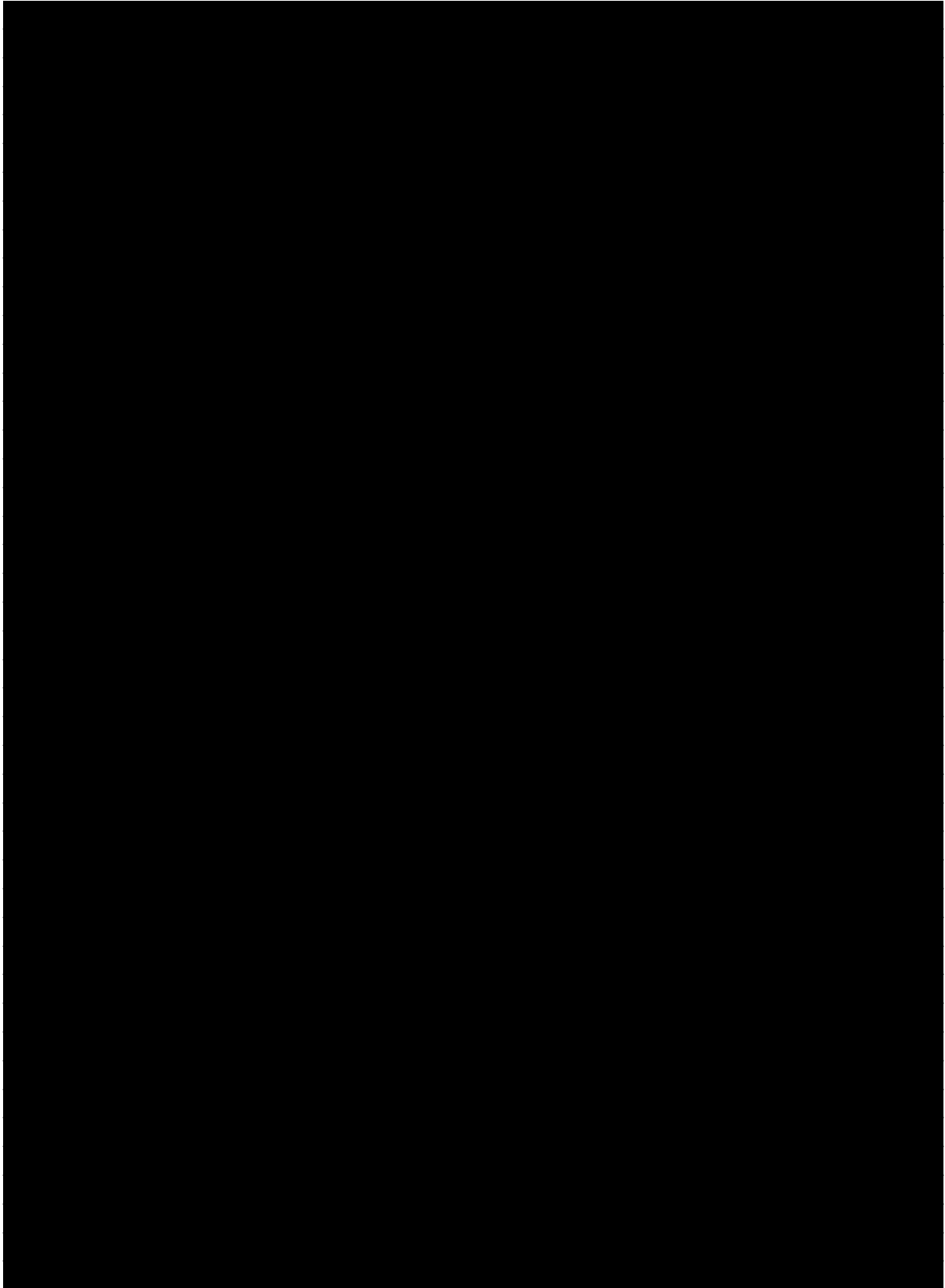
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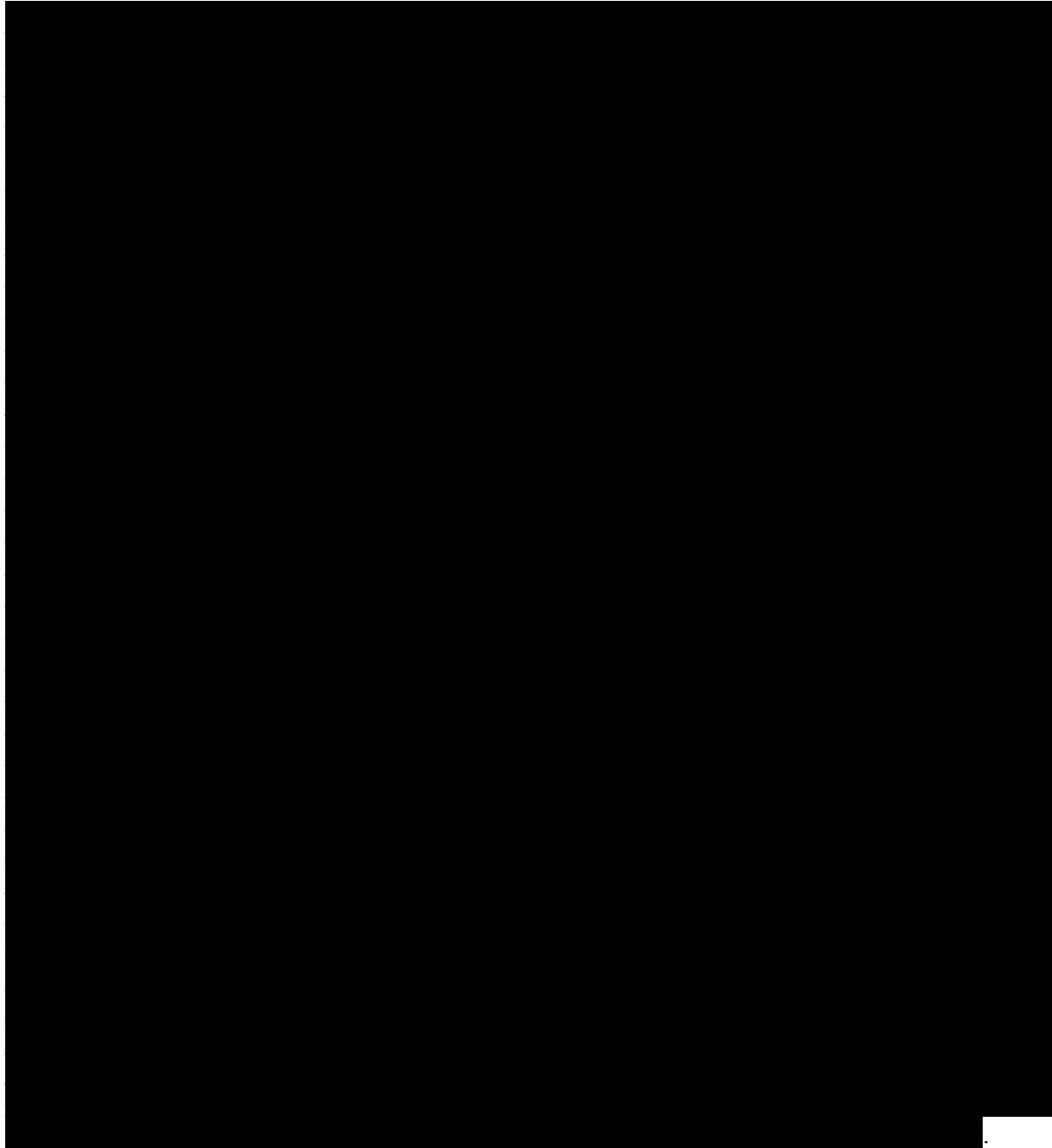




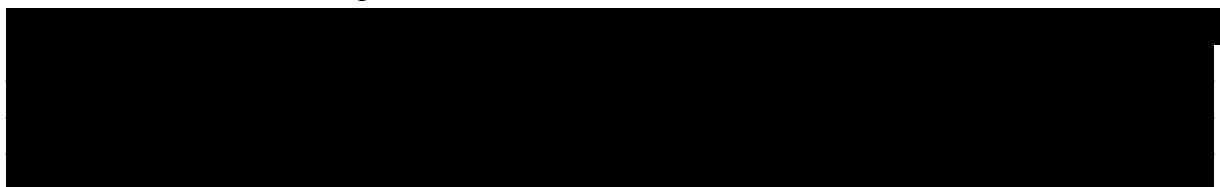


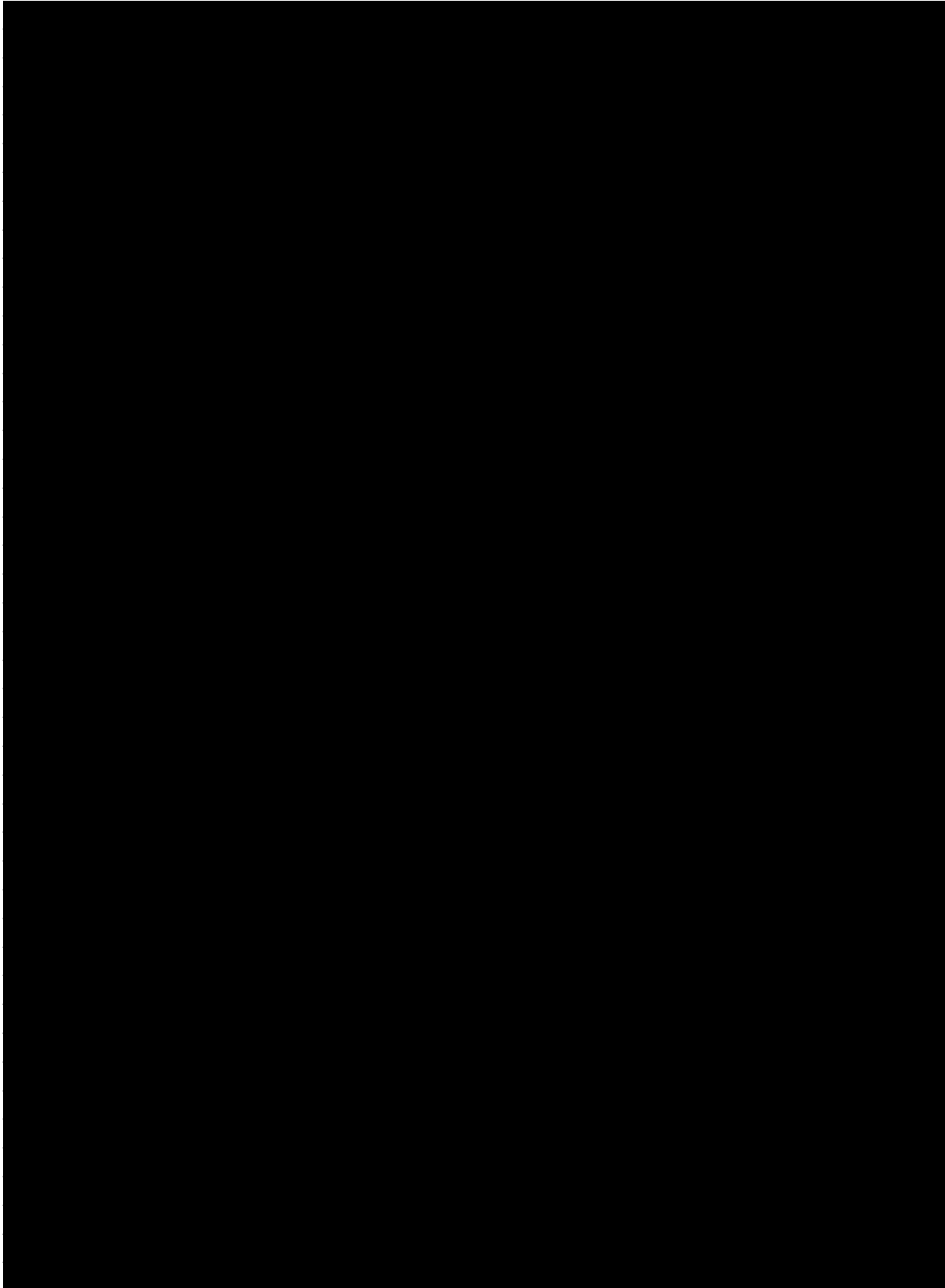


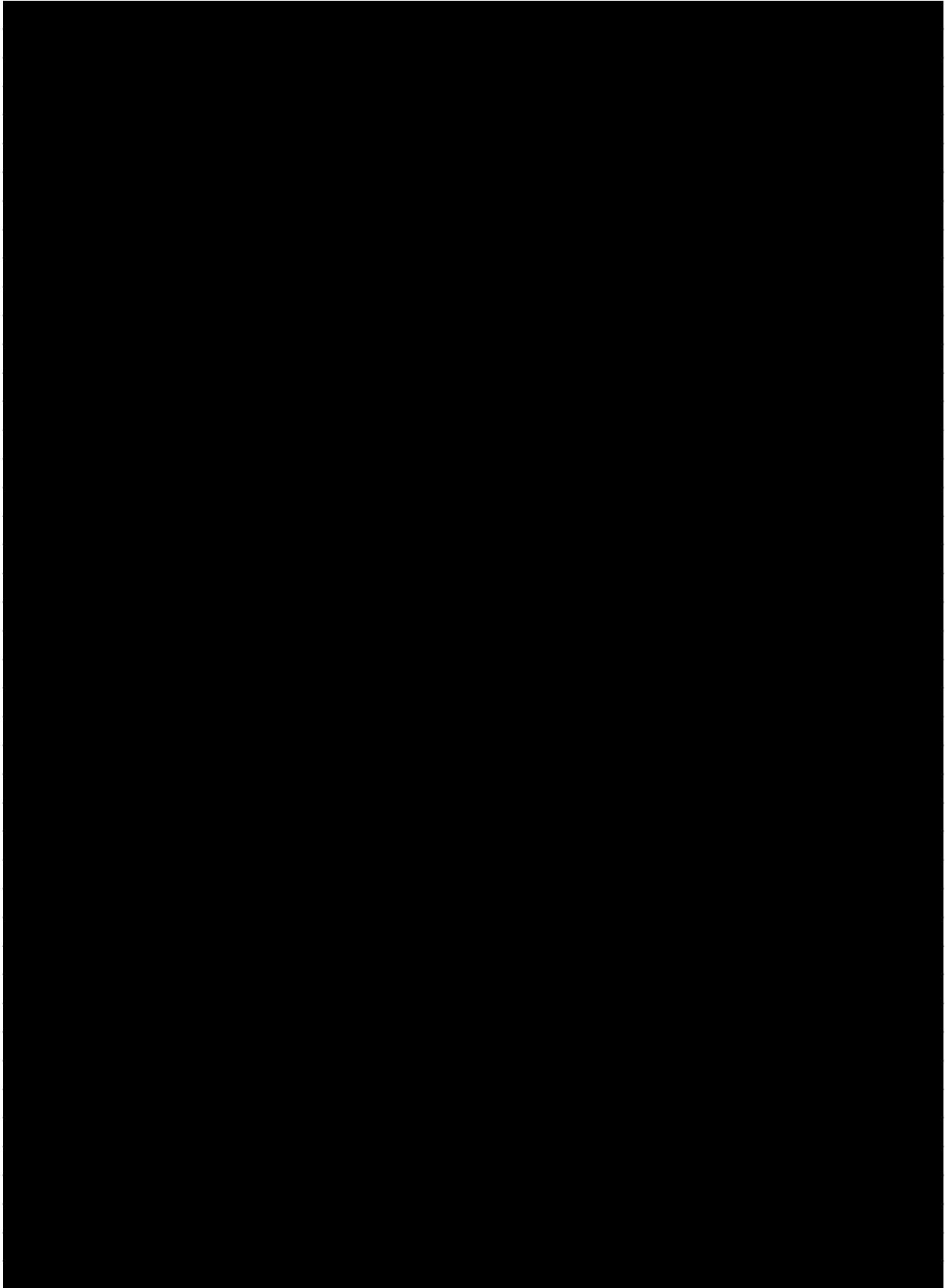




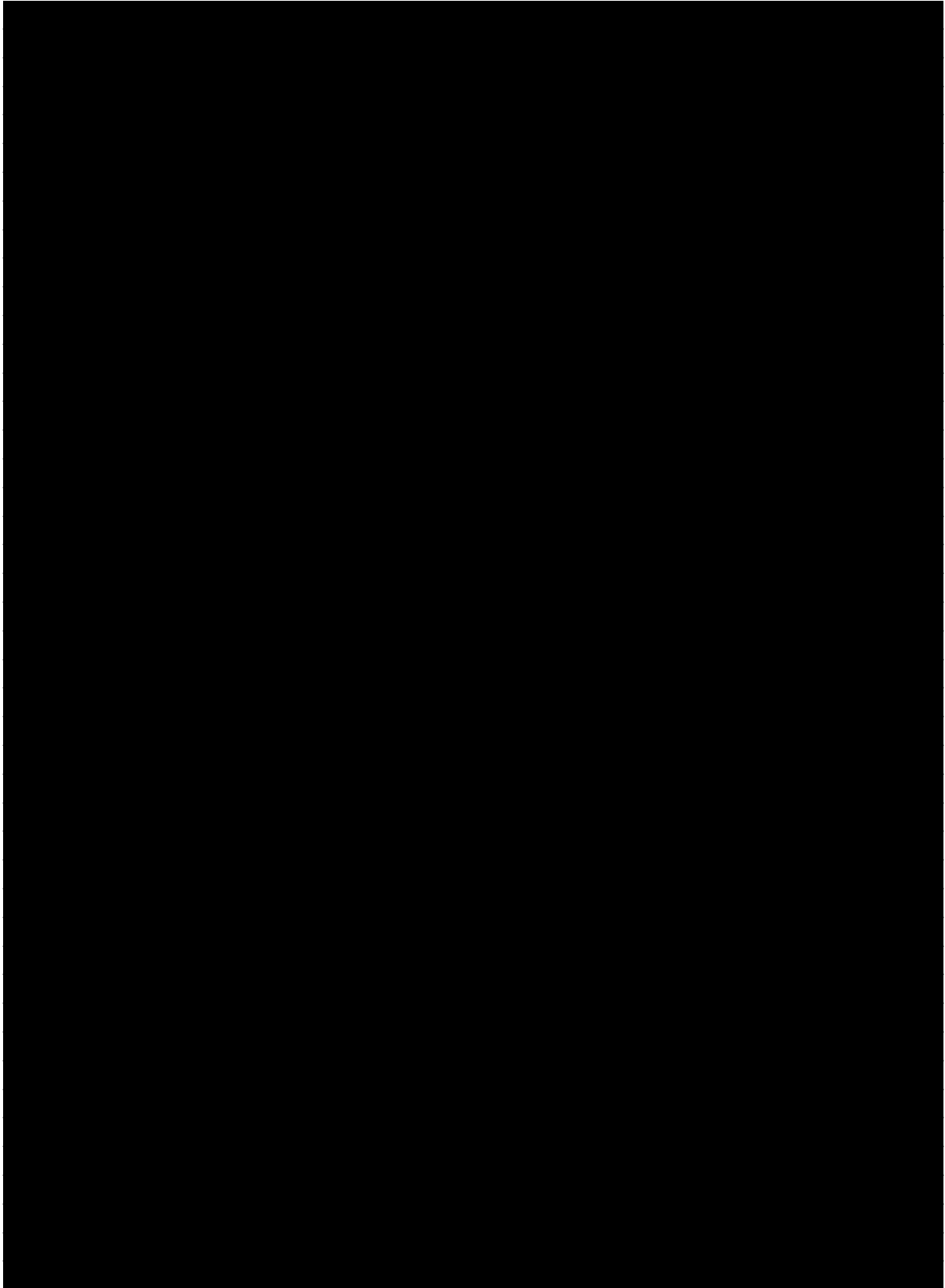
3. The definitions and eligibility requirements for “continuous personal care services,” “live-in 24-hour personal care services,” “continuous consumer directed personal assistance” and “live-in 24-hour consumer directed personal assistance” are revised as follows:

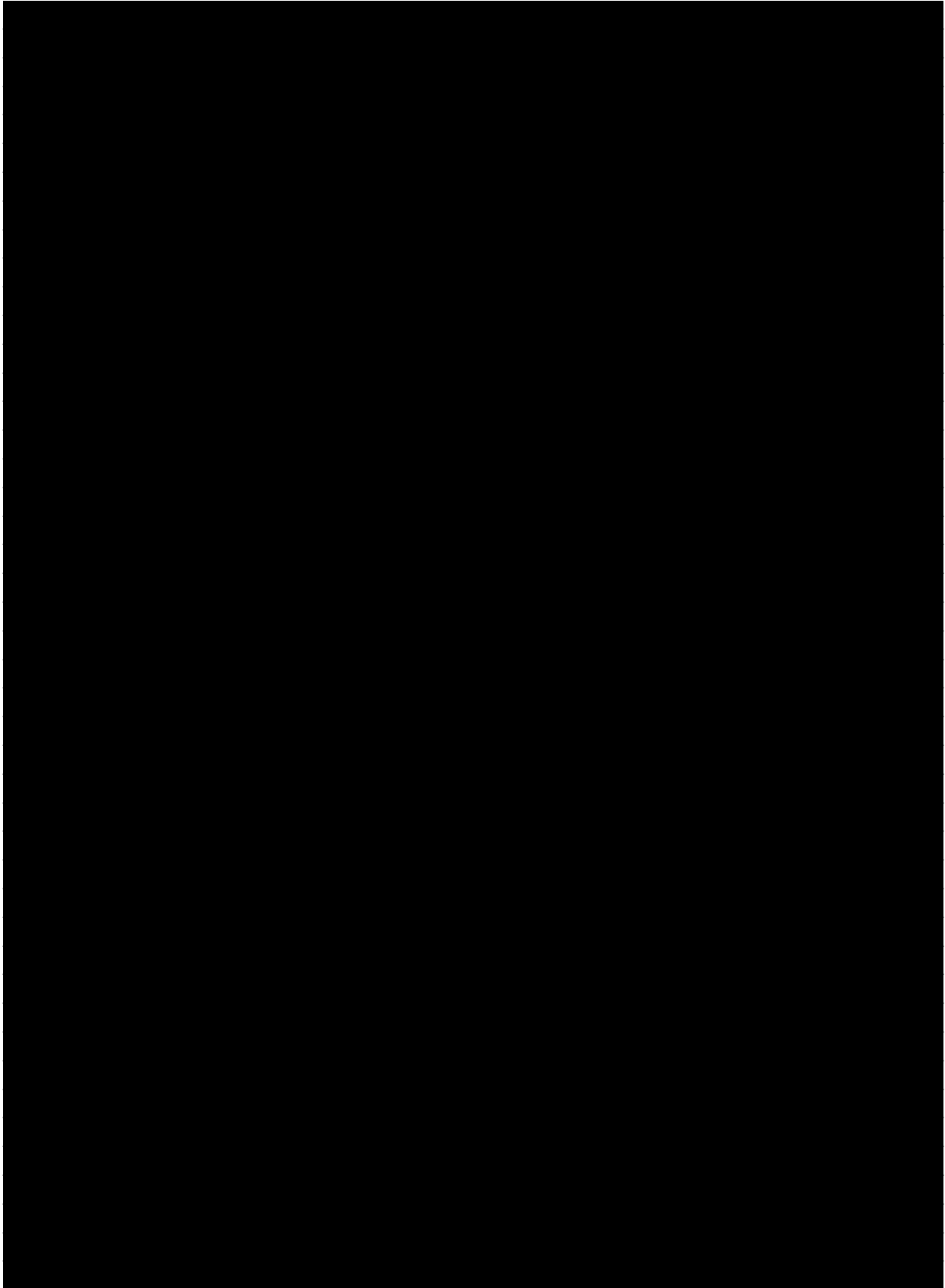




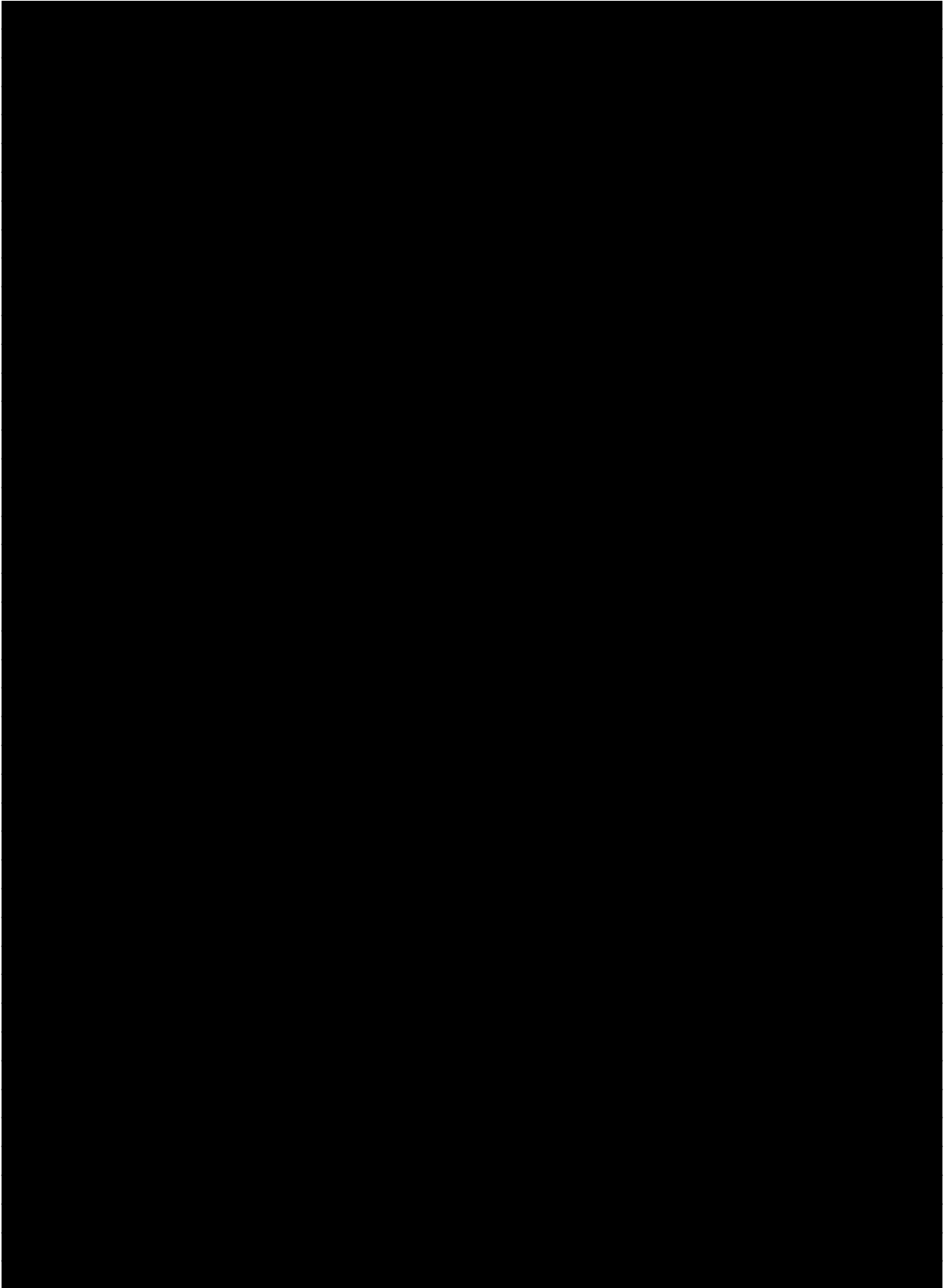


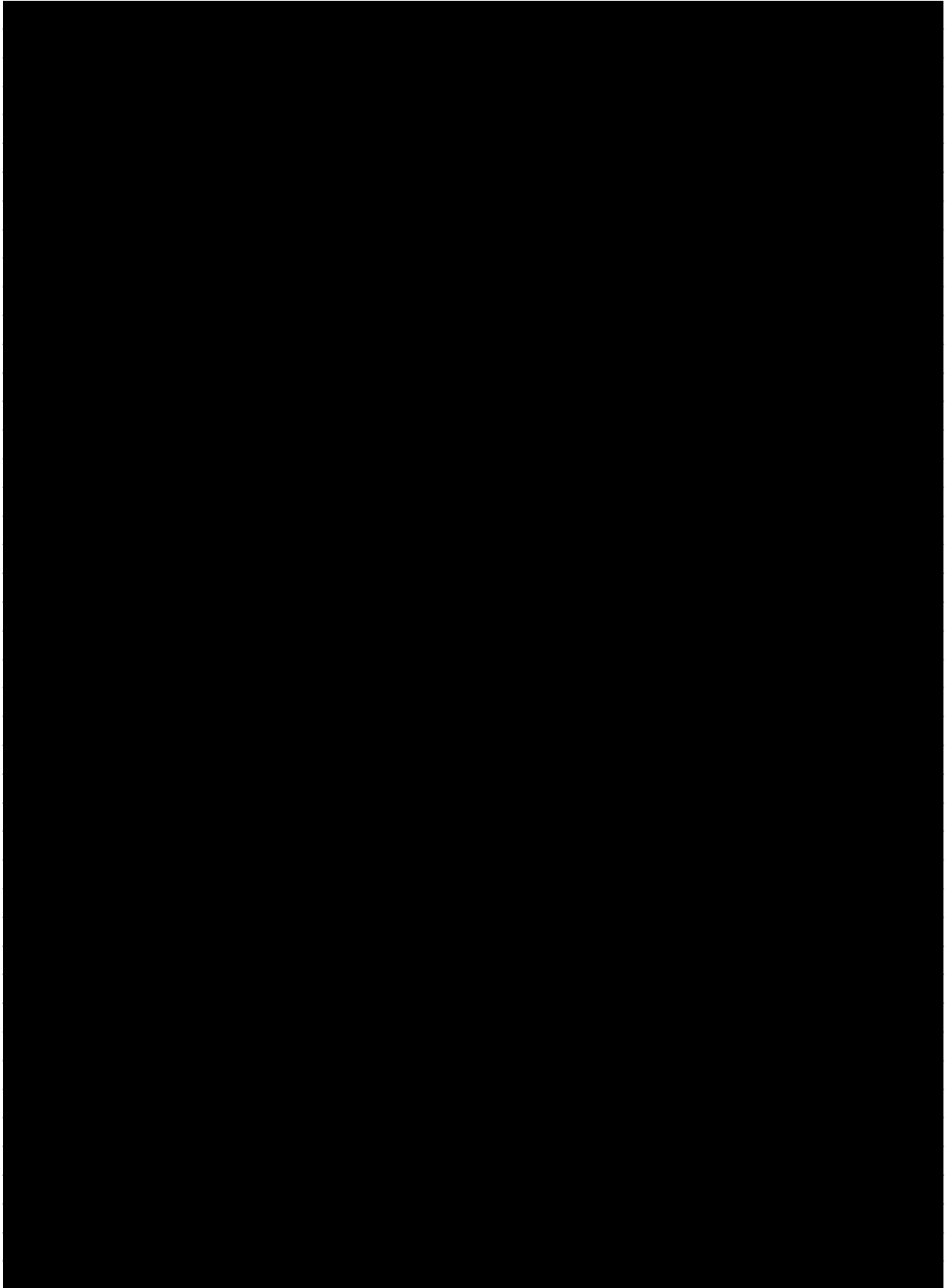
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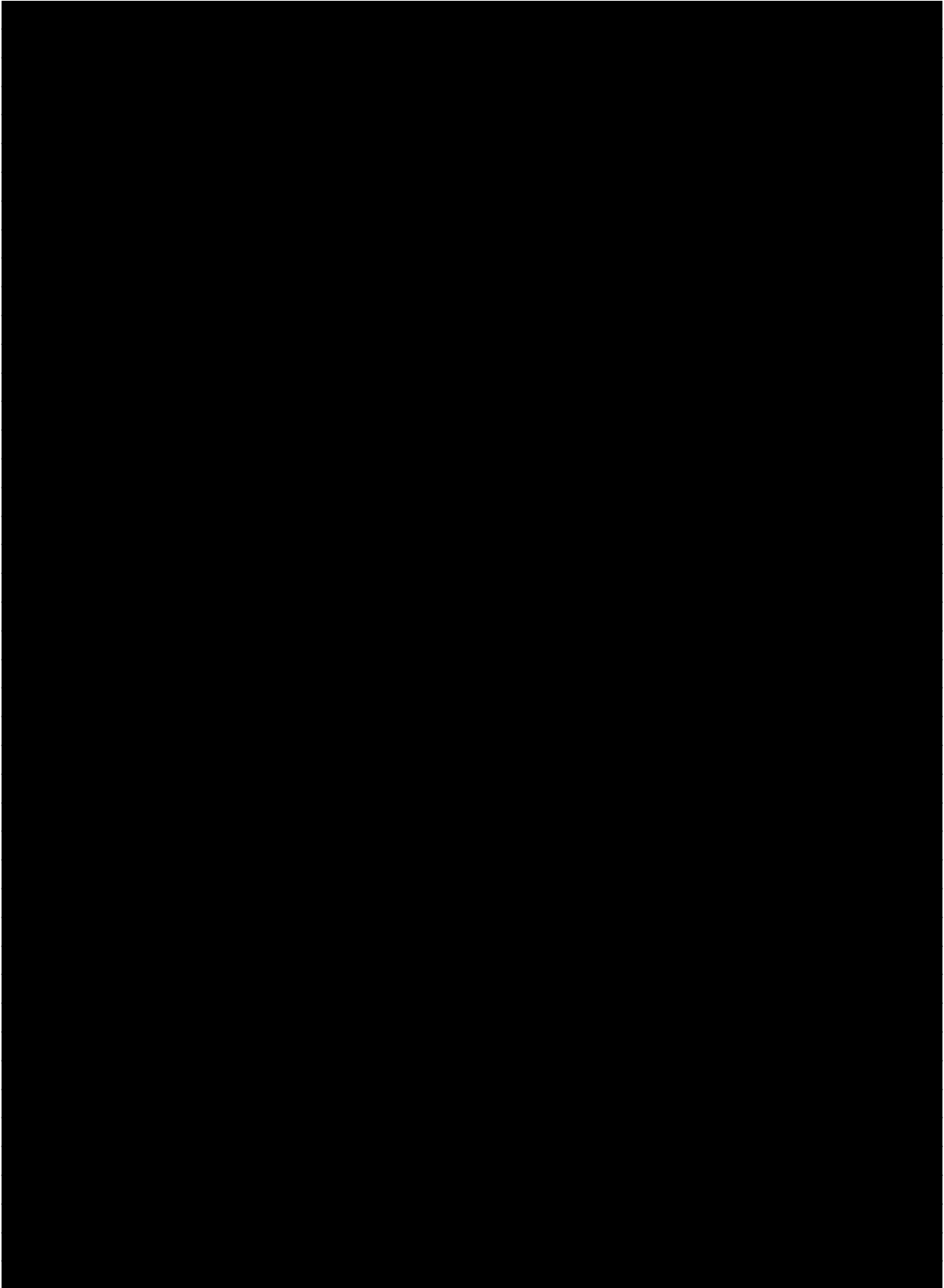


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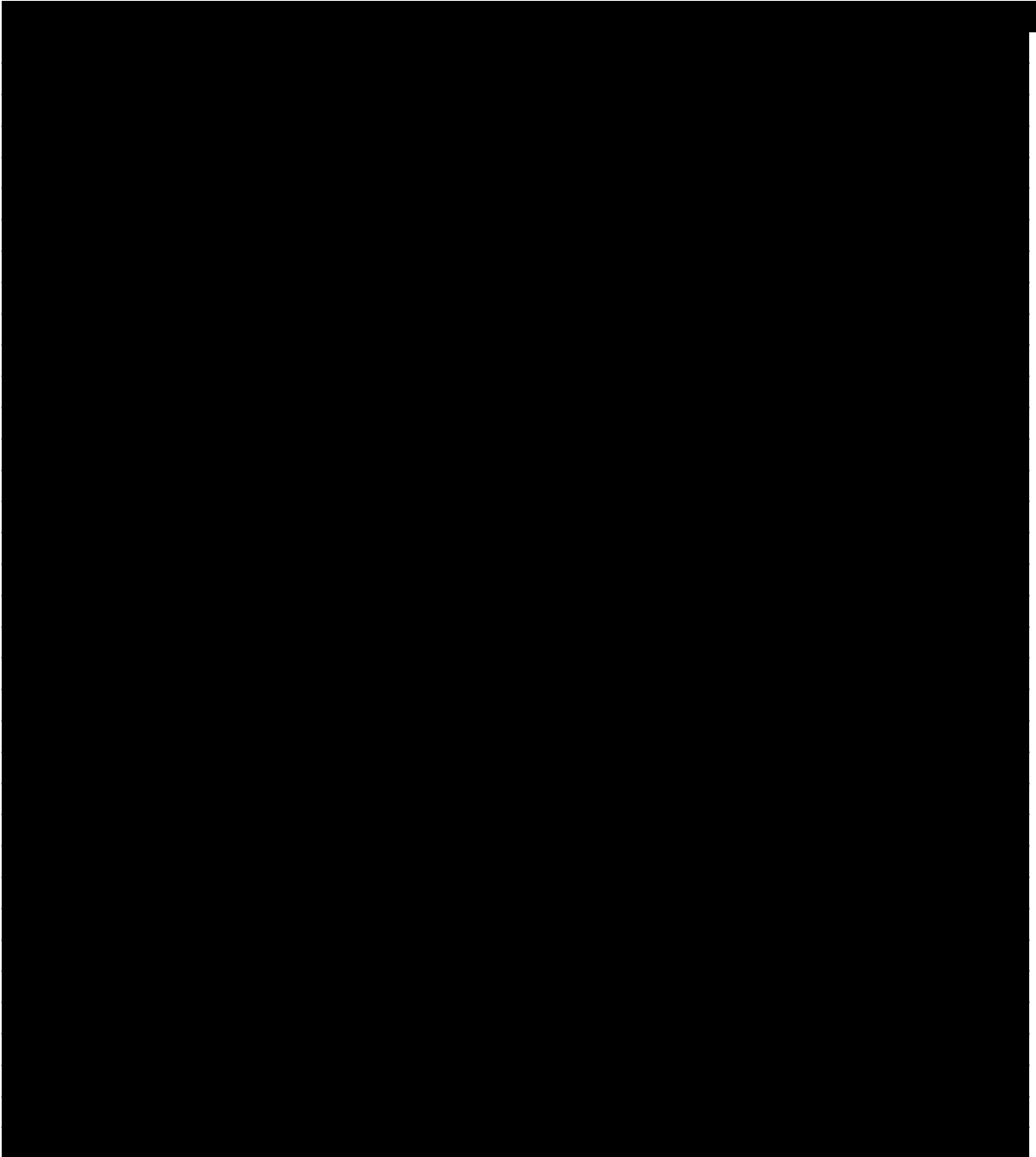


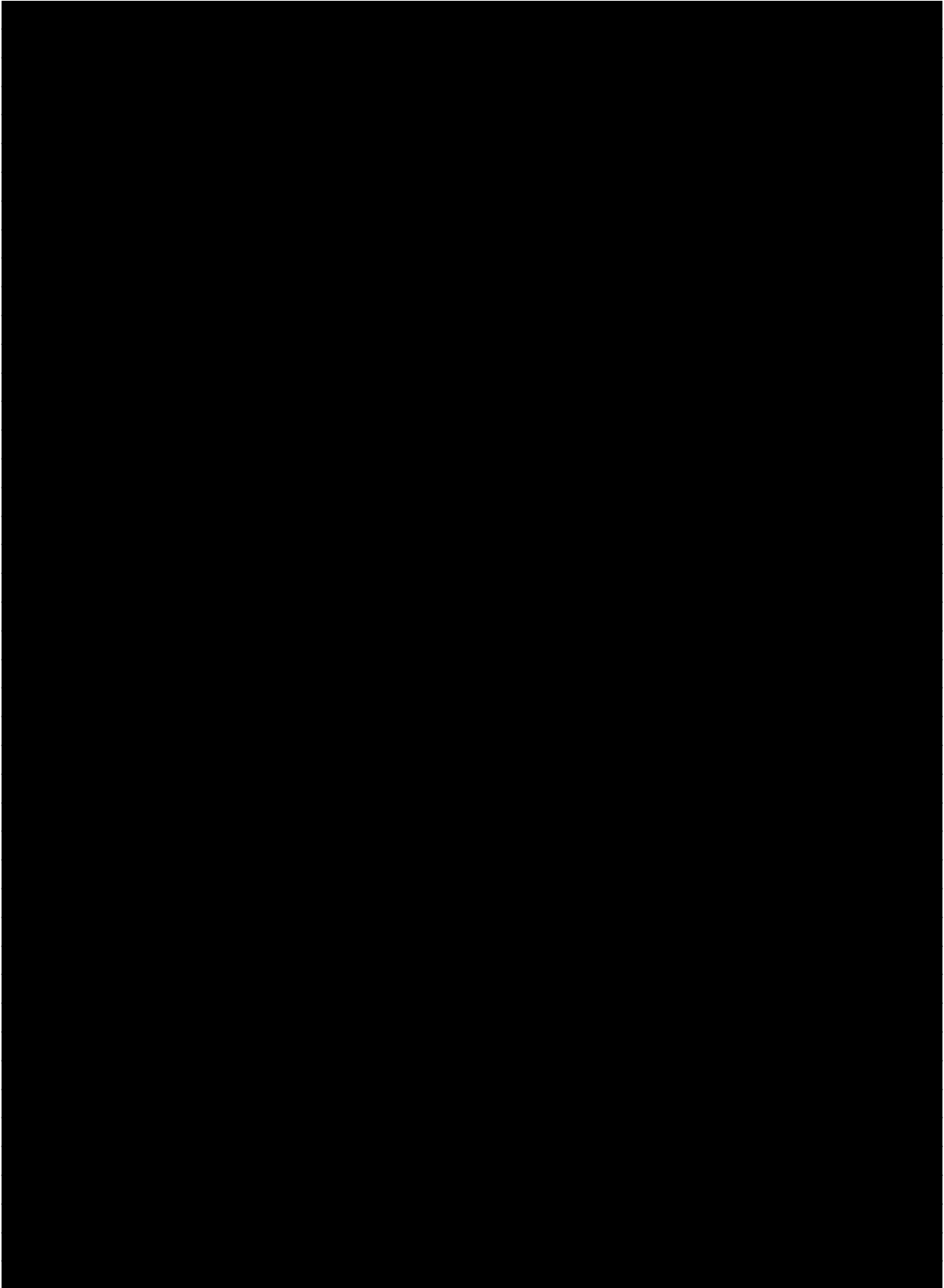


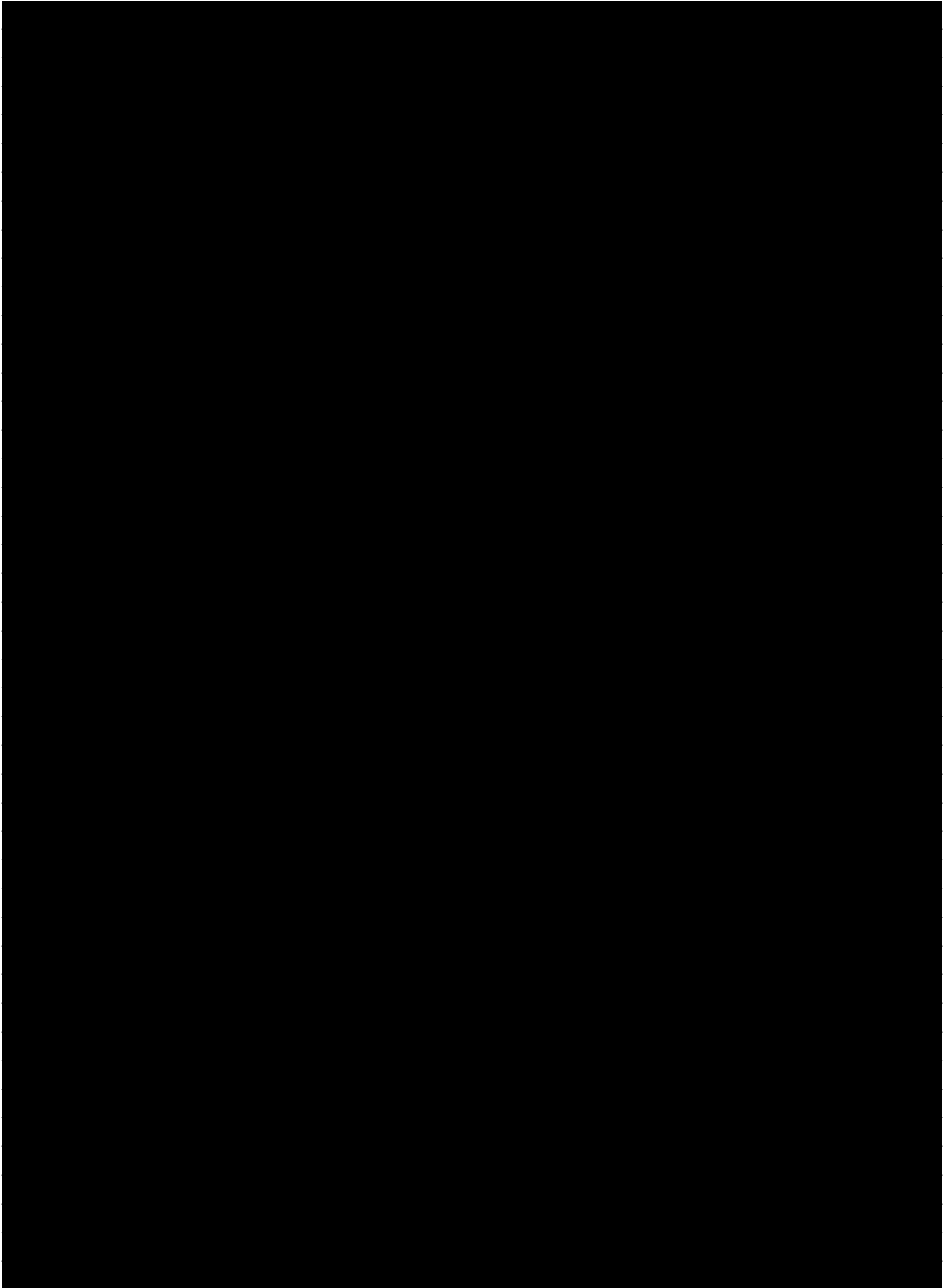
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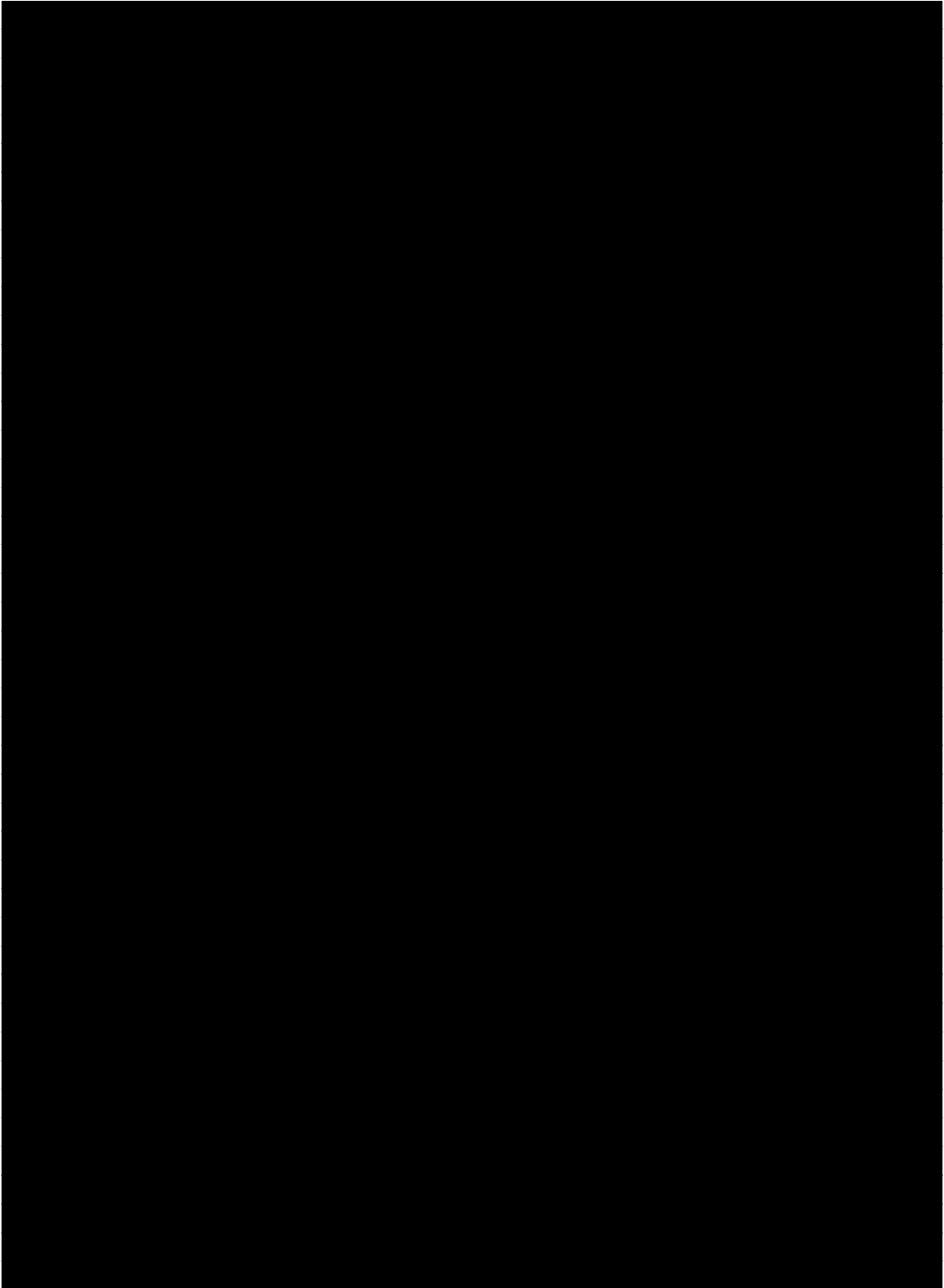


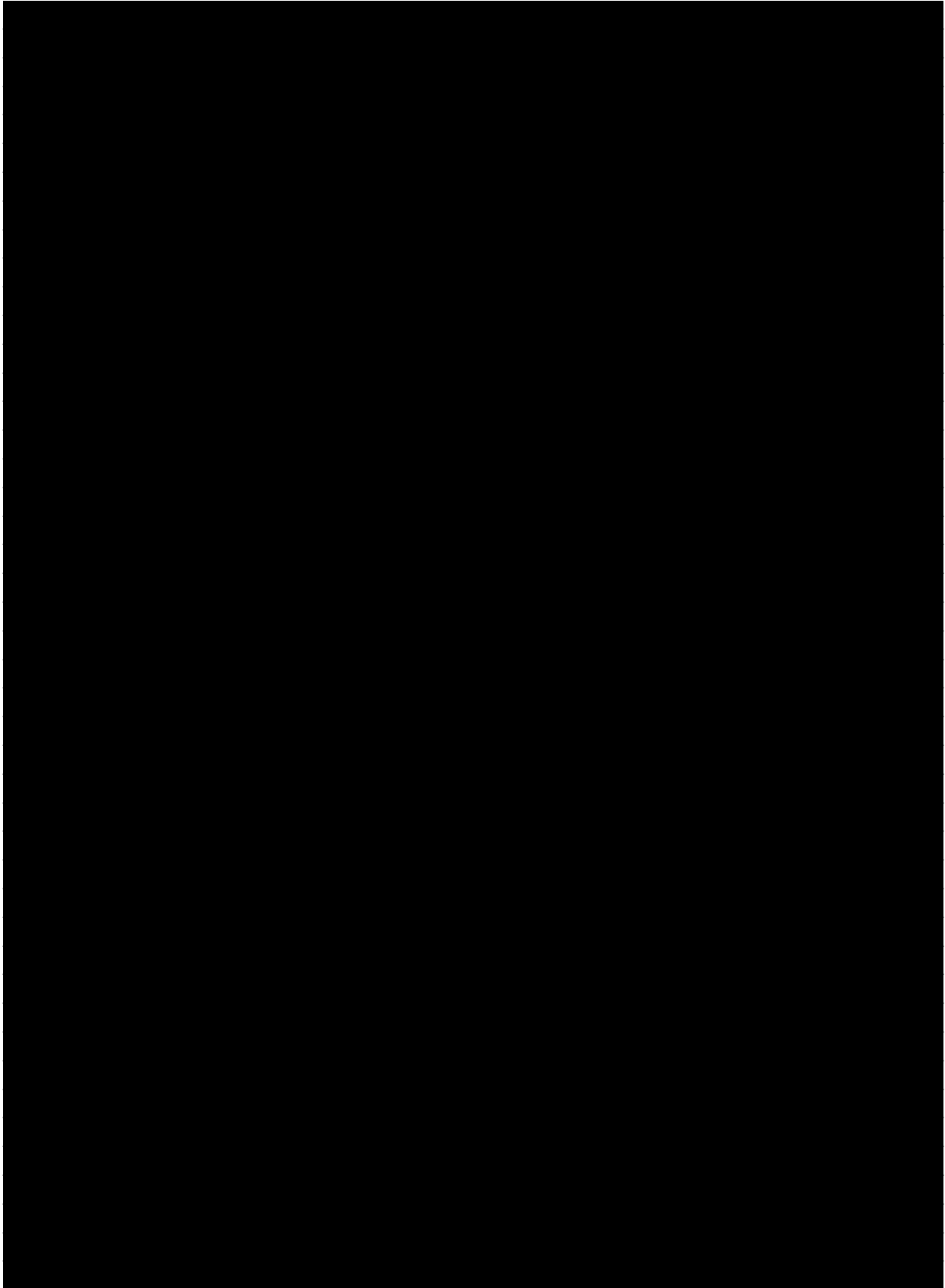
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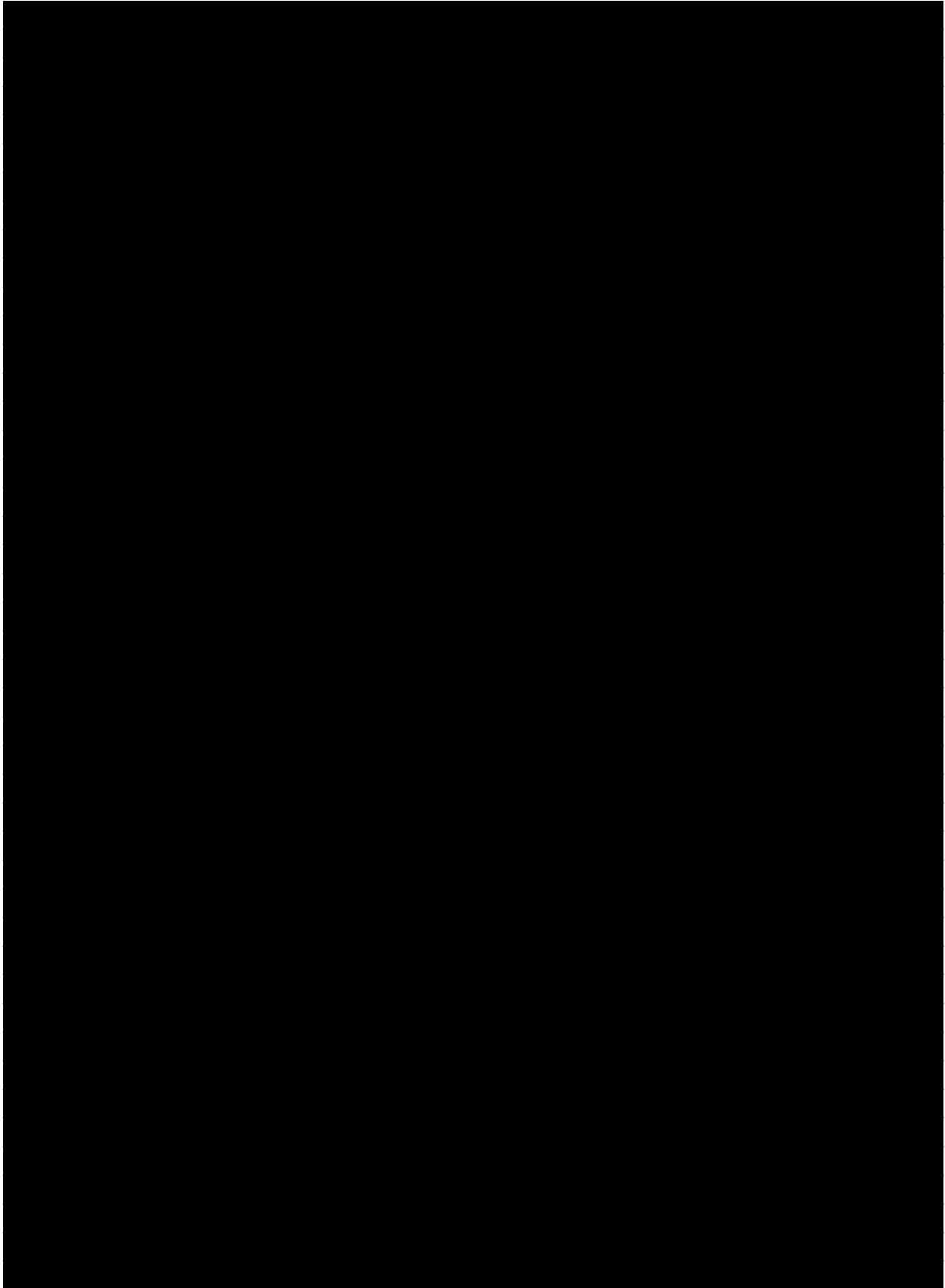


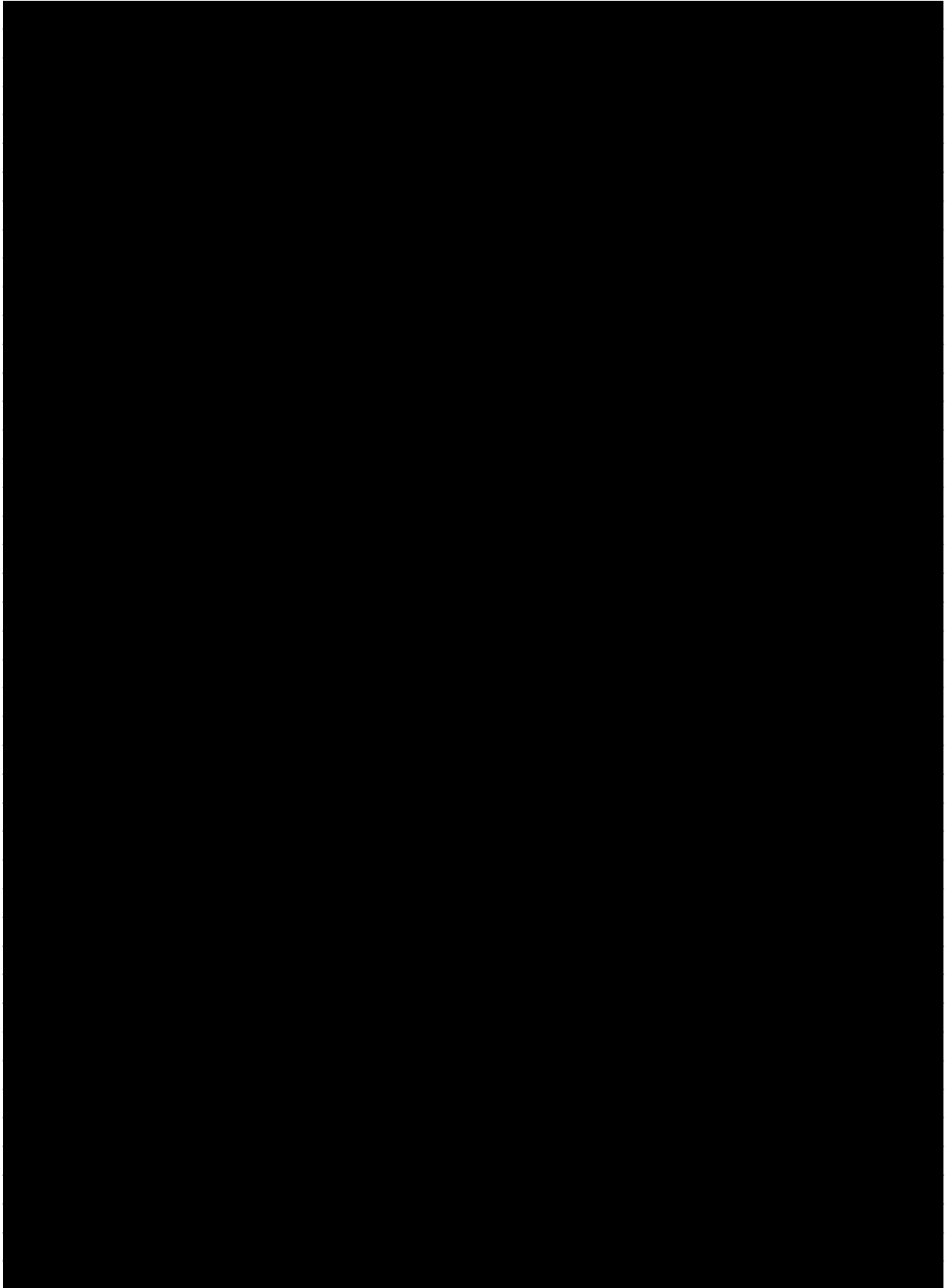




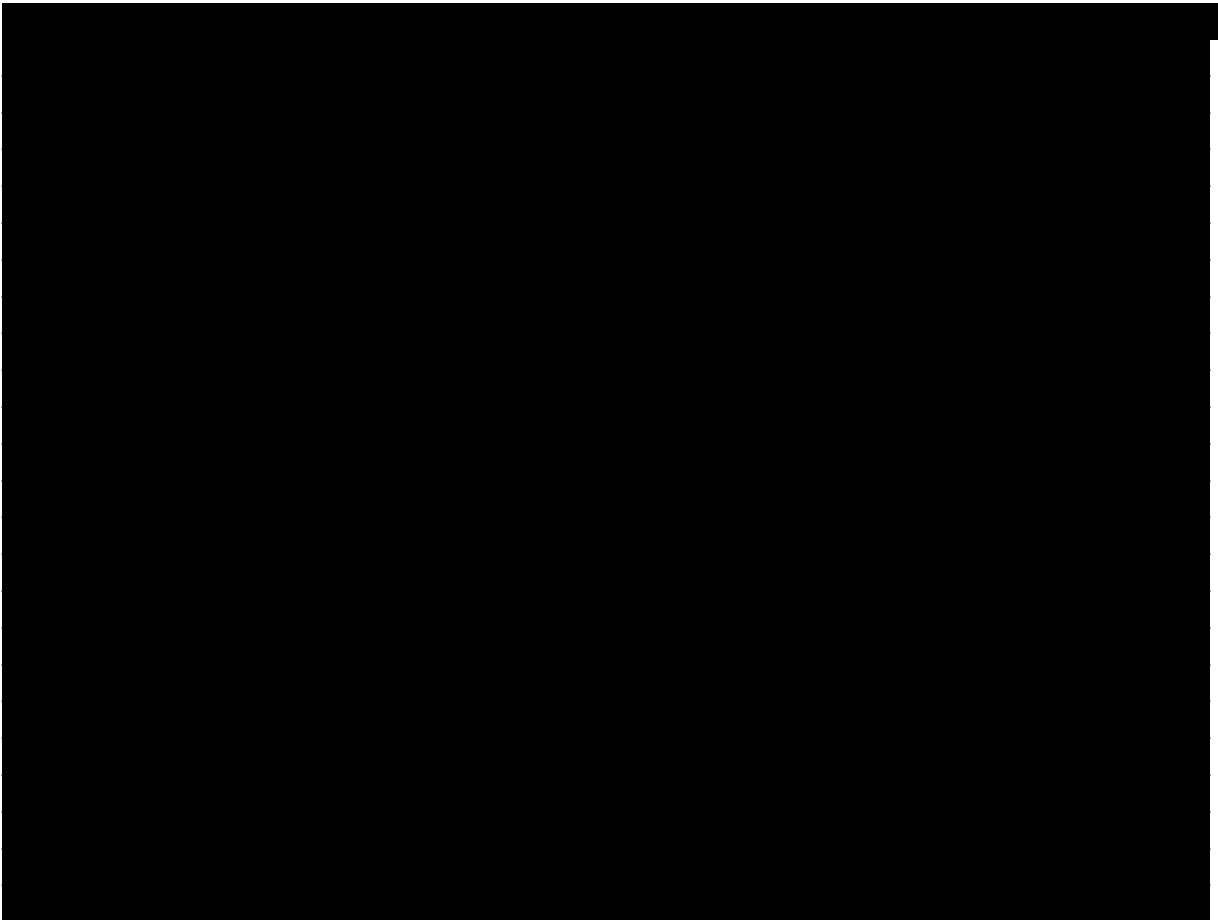
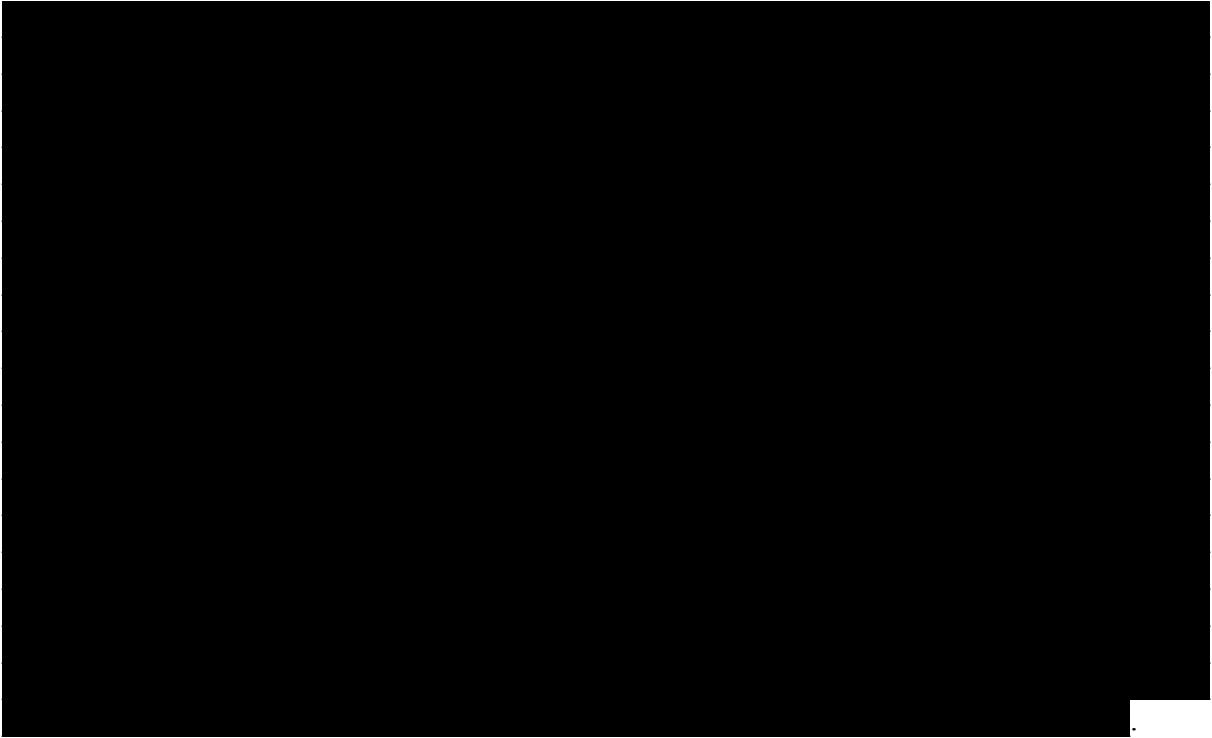


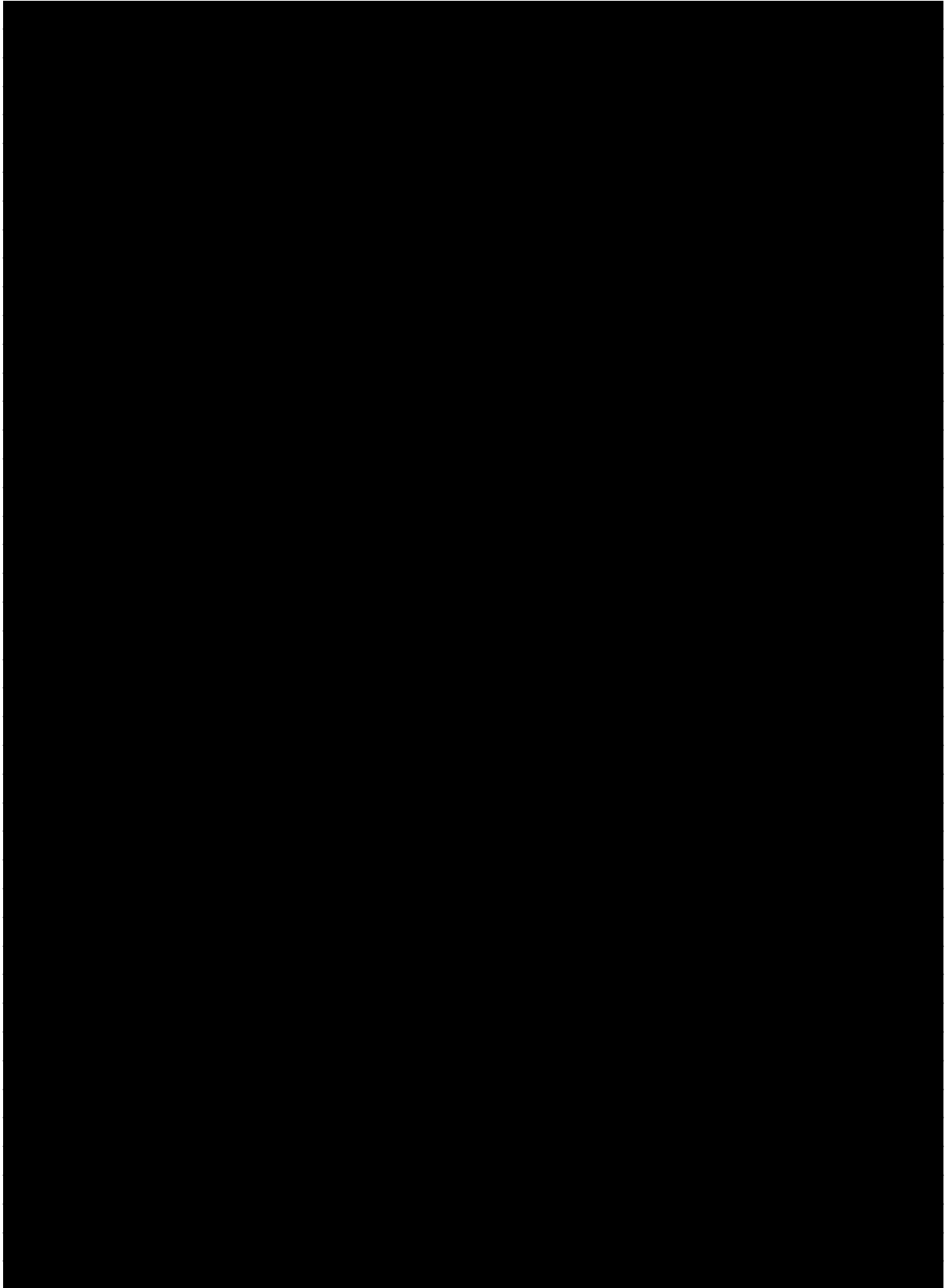




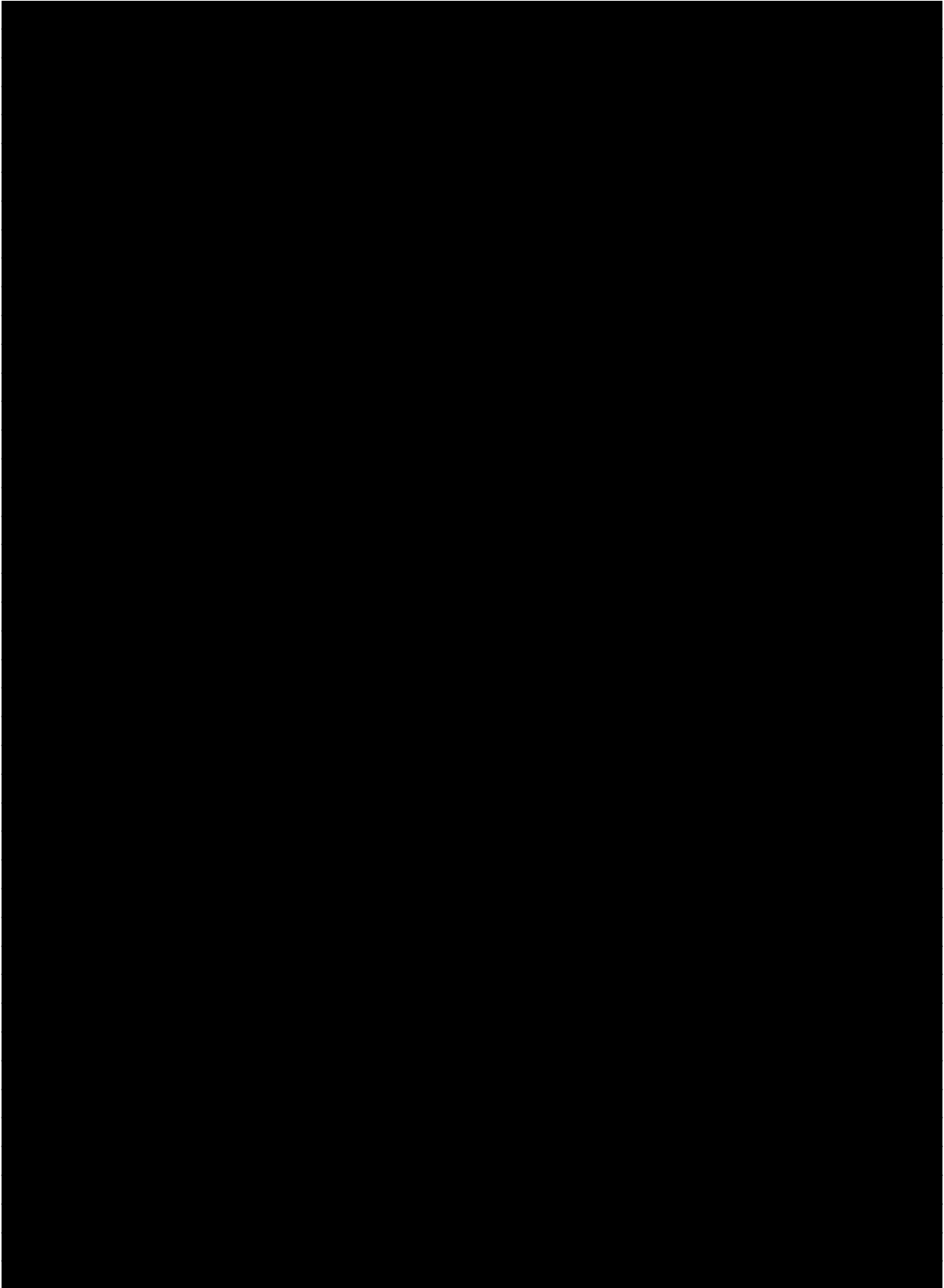


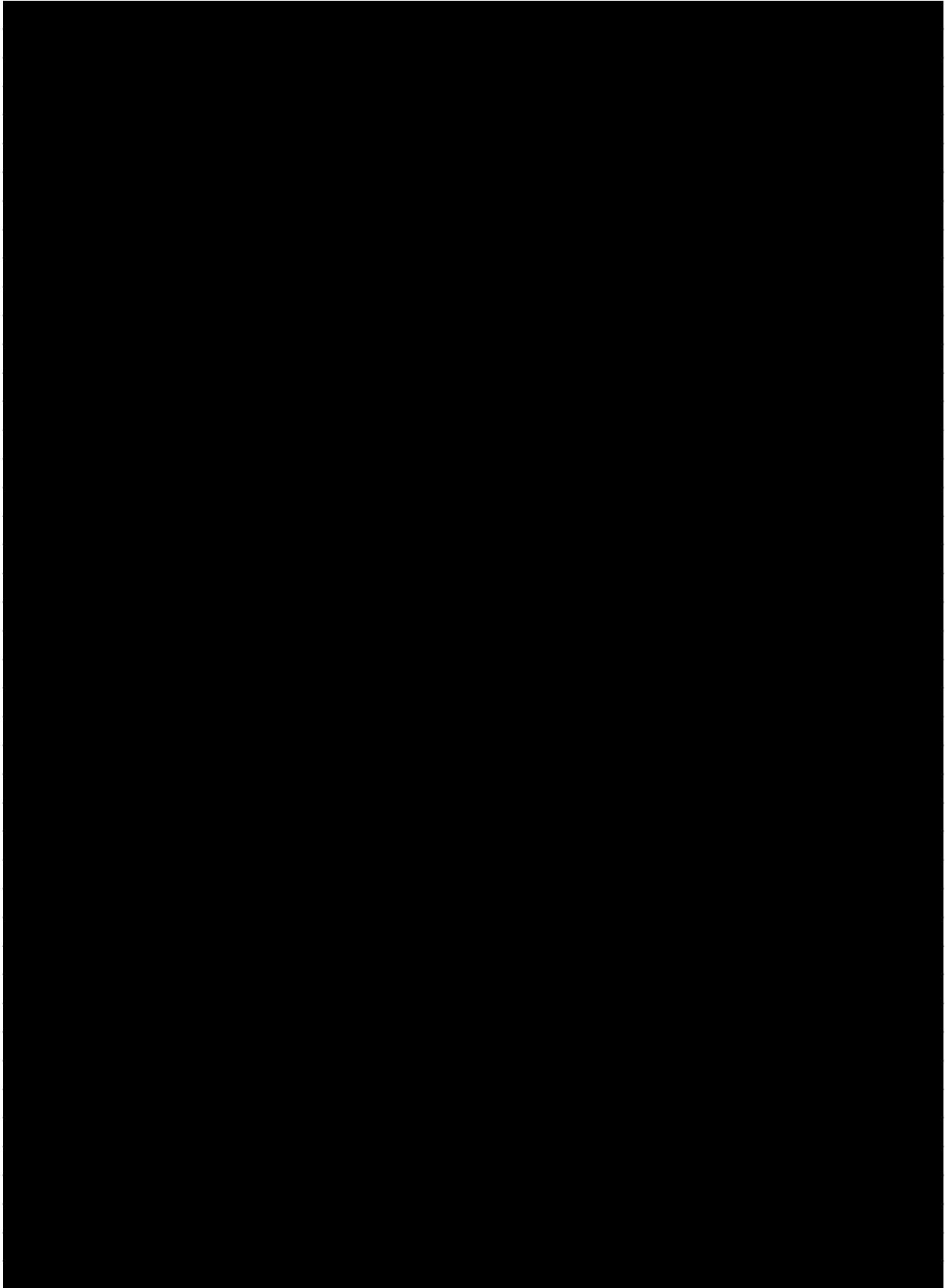
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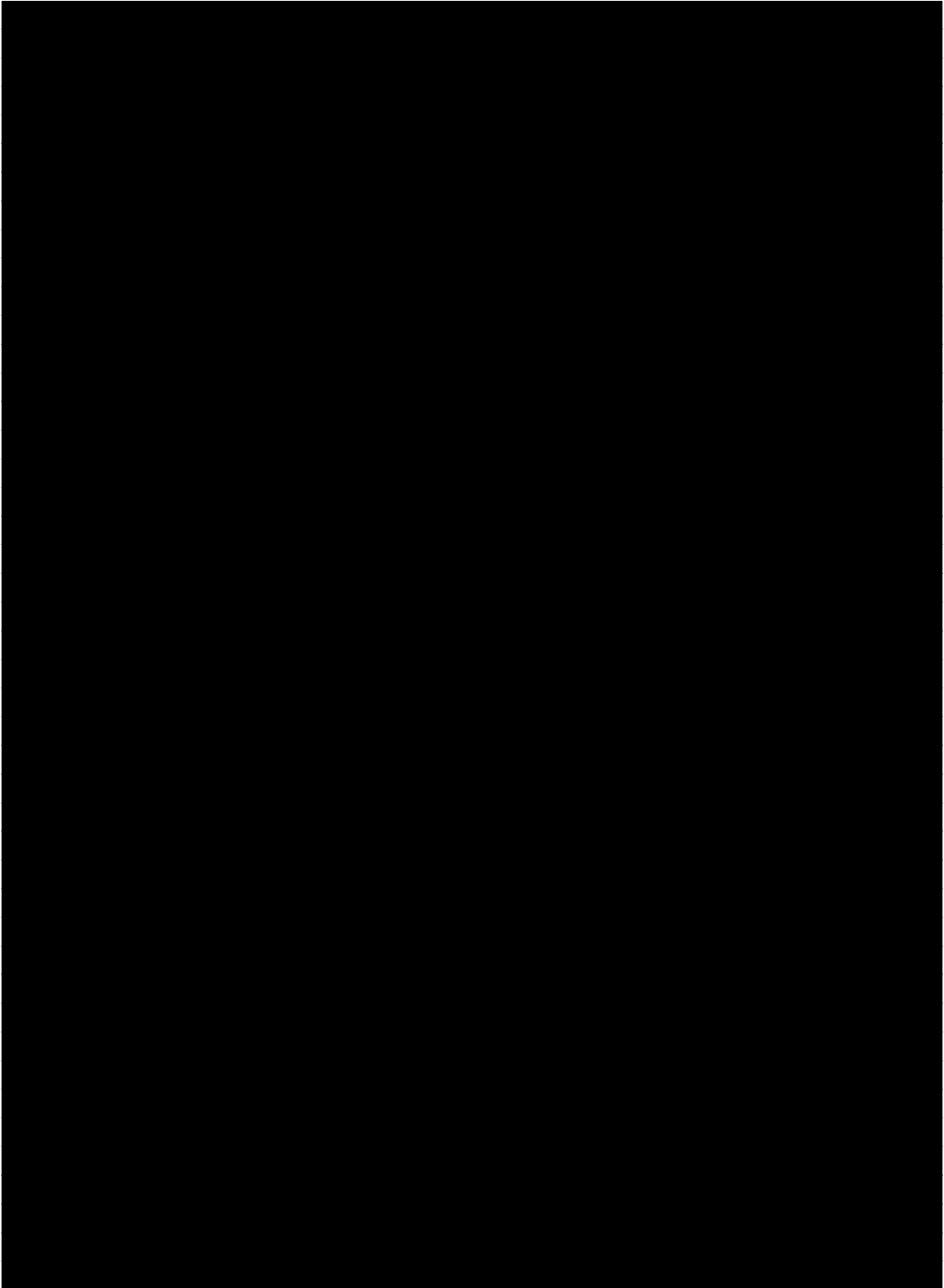


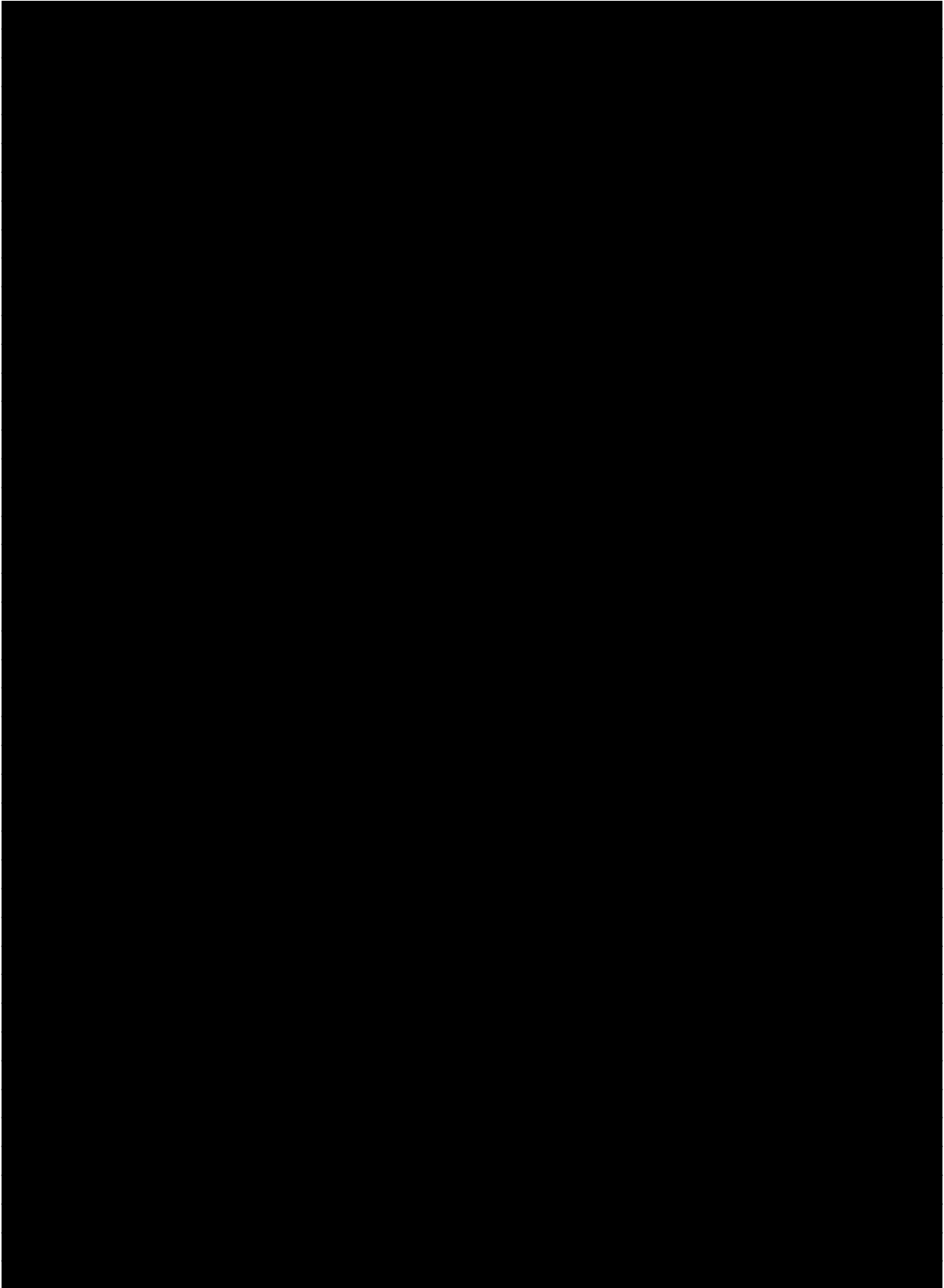
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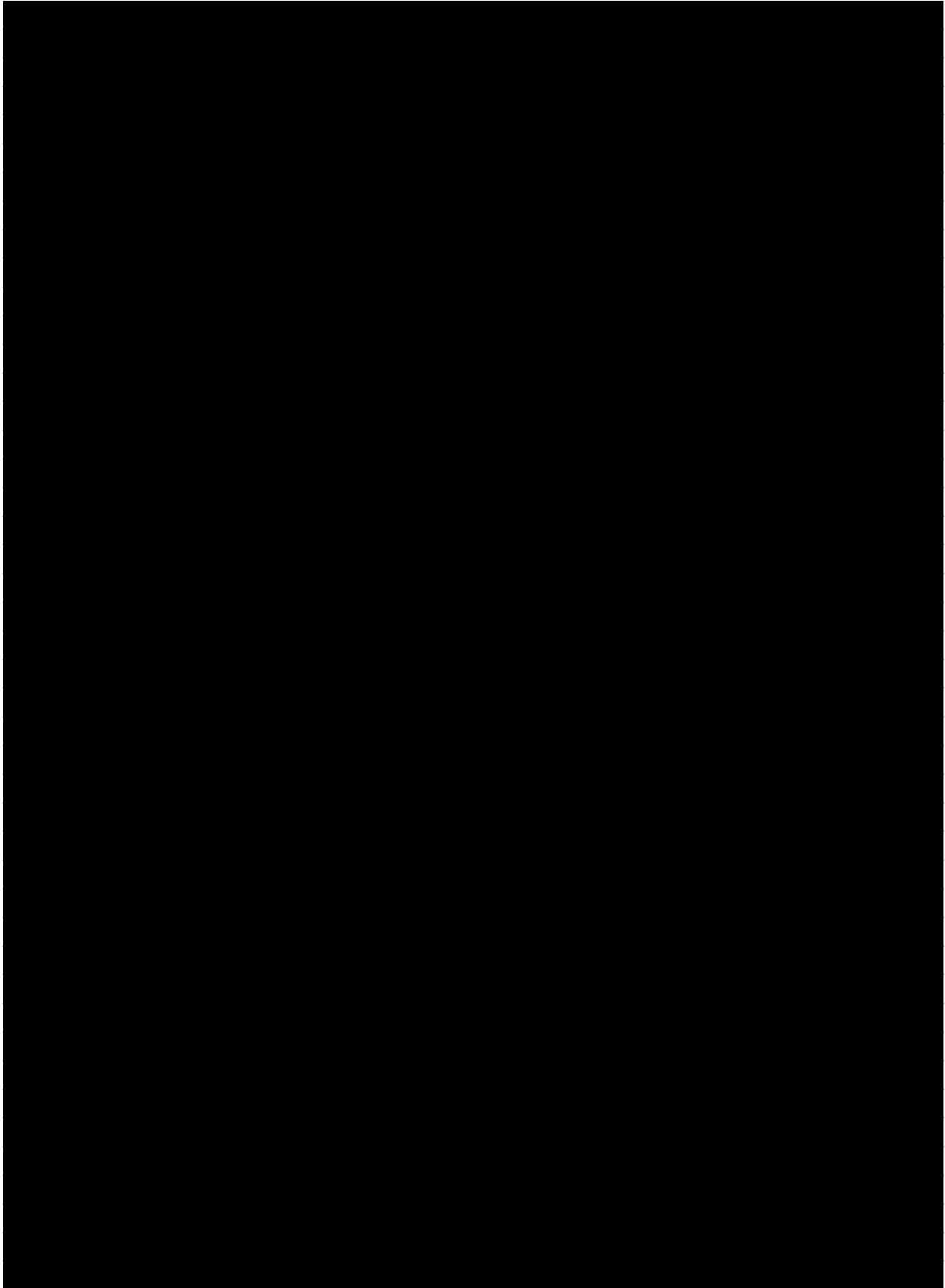


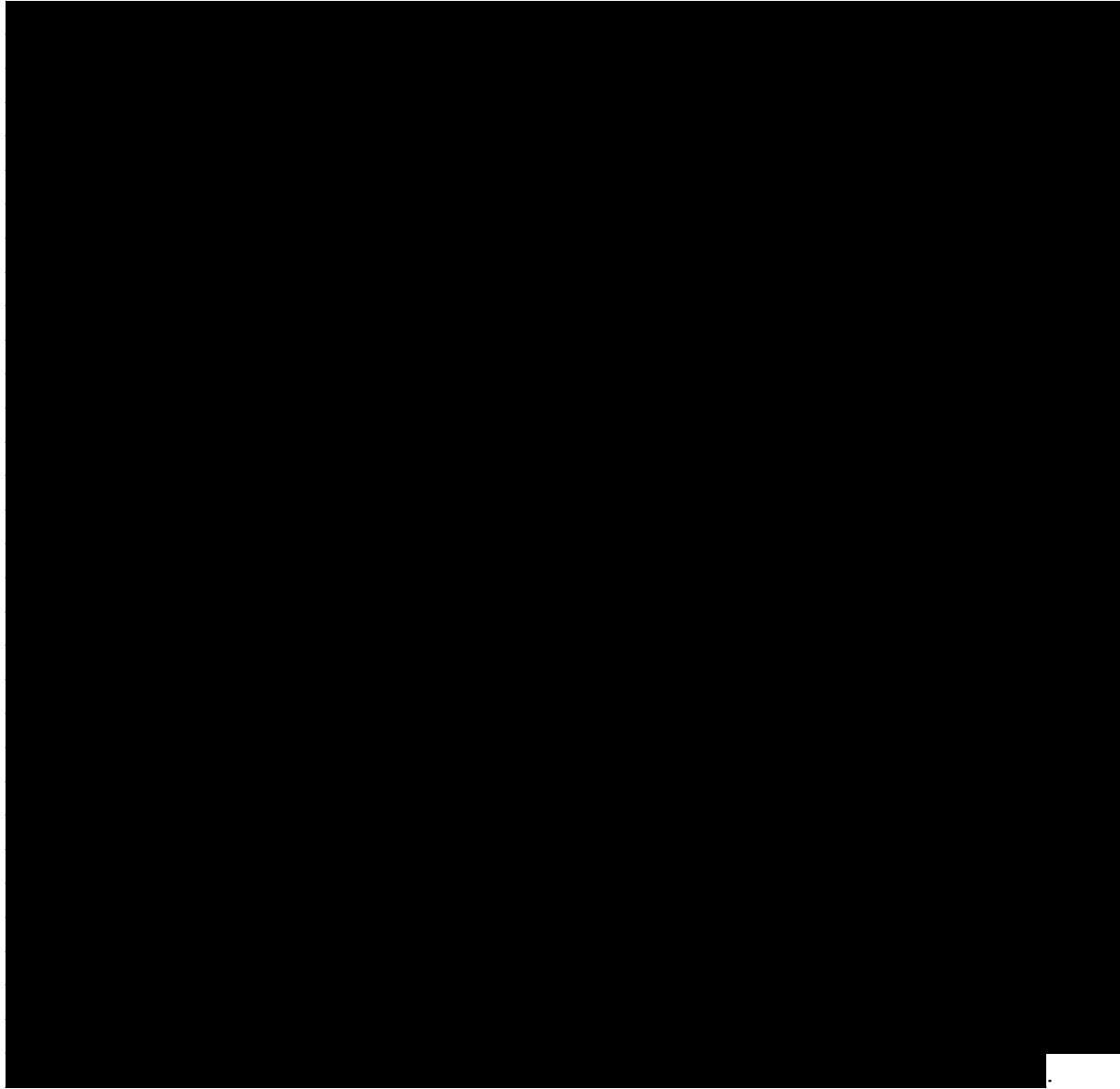
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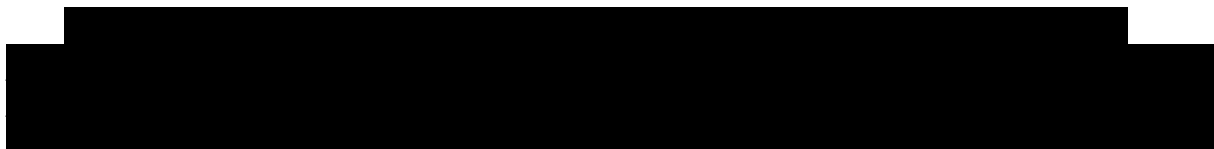


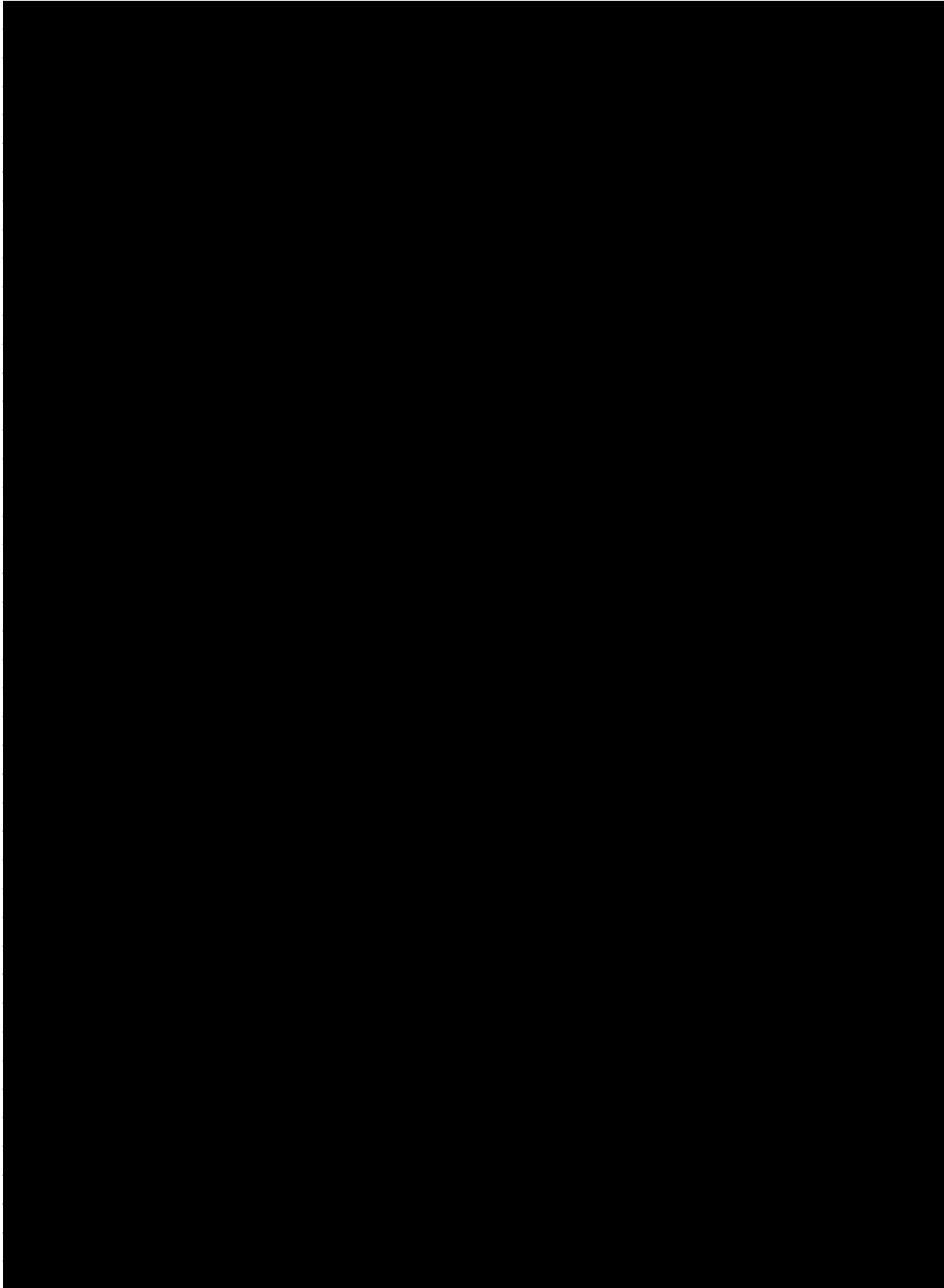
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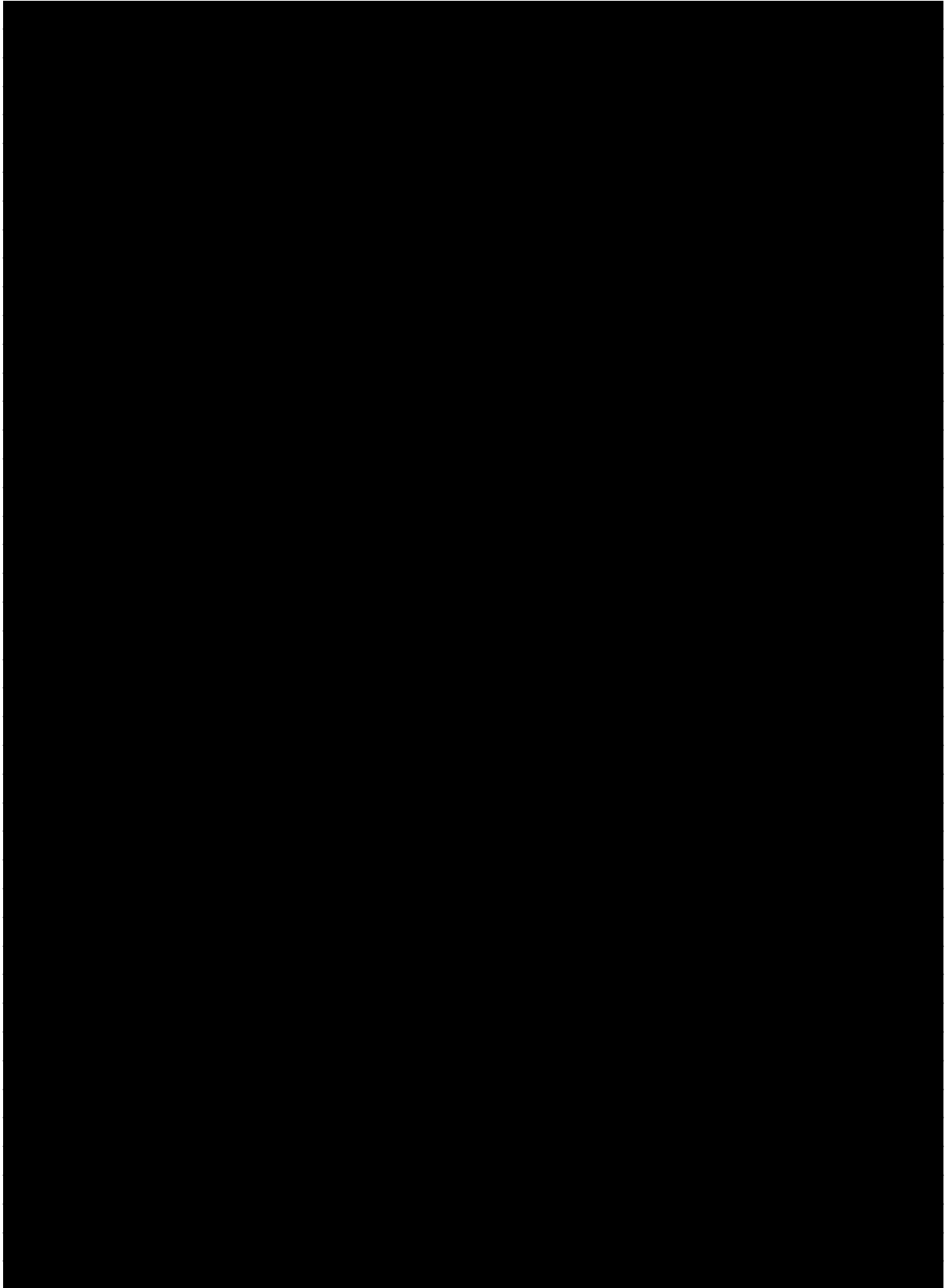




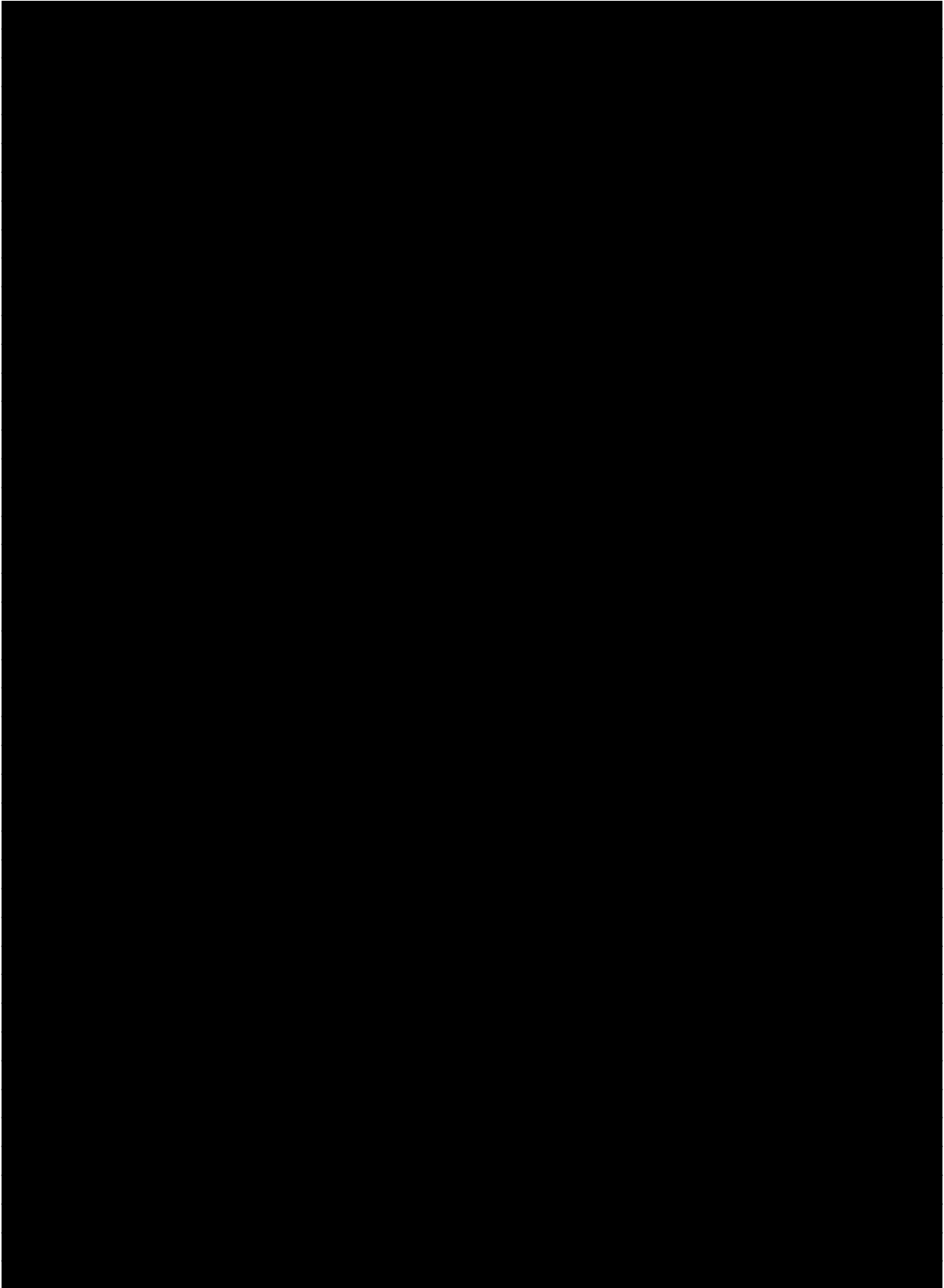
d. *Live-in 24-hour consumer directed personal assistance* means the provision of care by one consumer directed personal assistant for a consumer who, because of the consumer's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks and whose need for assistance is sufficiently infrequent that a live-in 24-hour consumer directed personal assistant would be likely to obtain, on a regular basis, five hours per day of uninterrupted sleep during the aide's eight hour period of sleep.



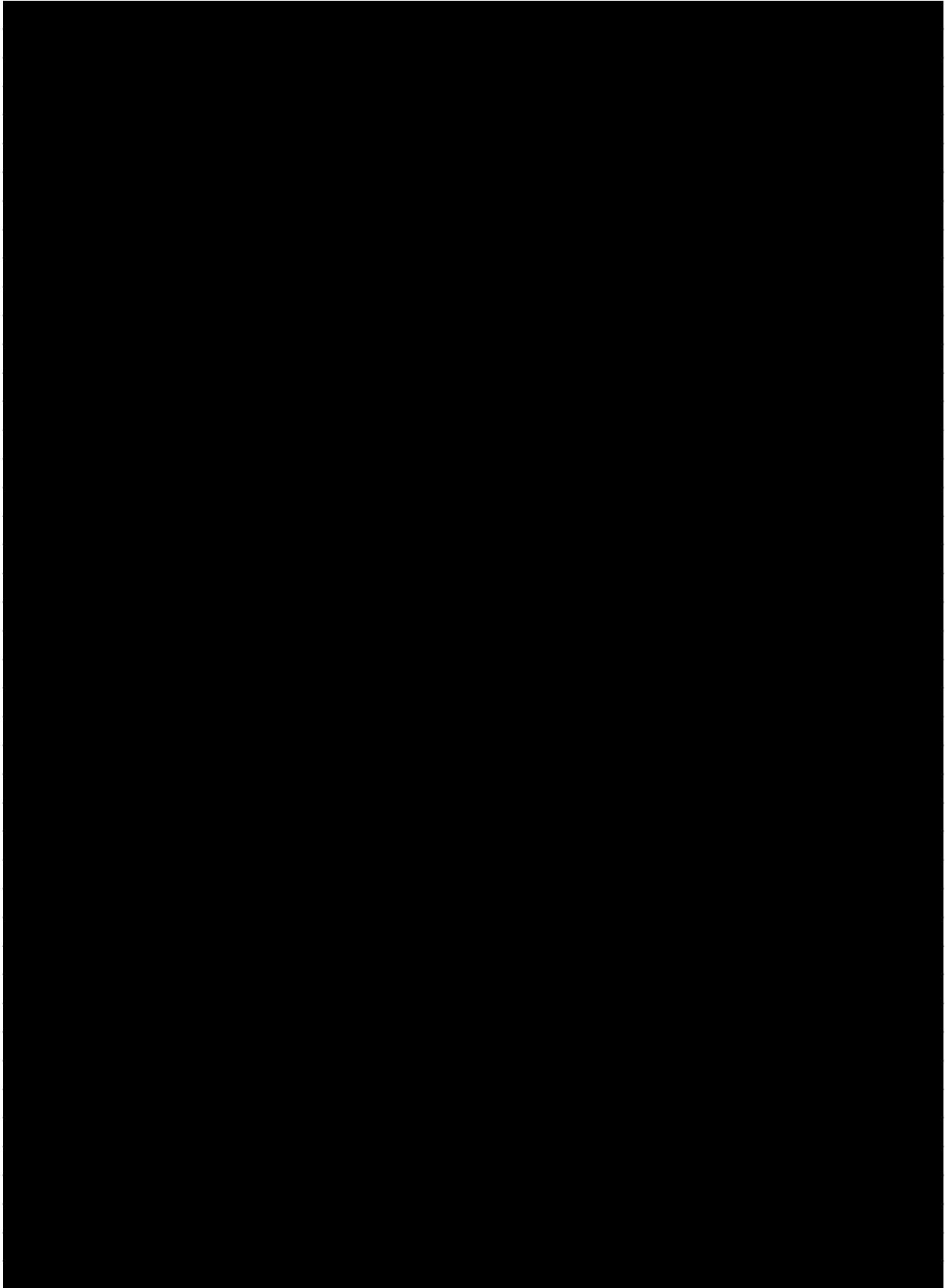




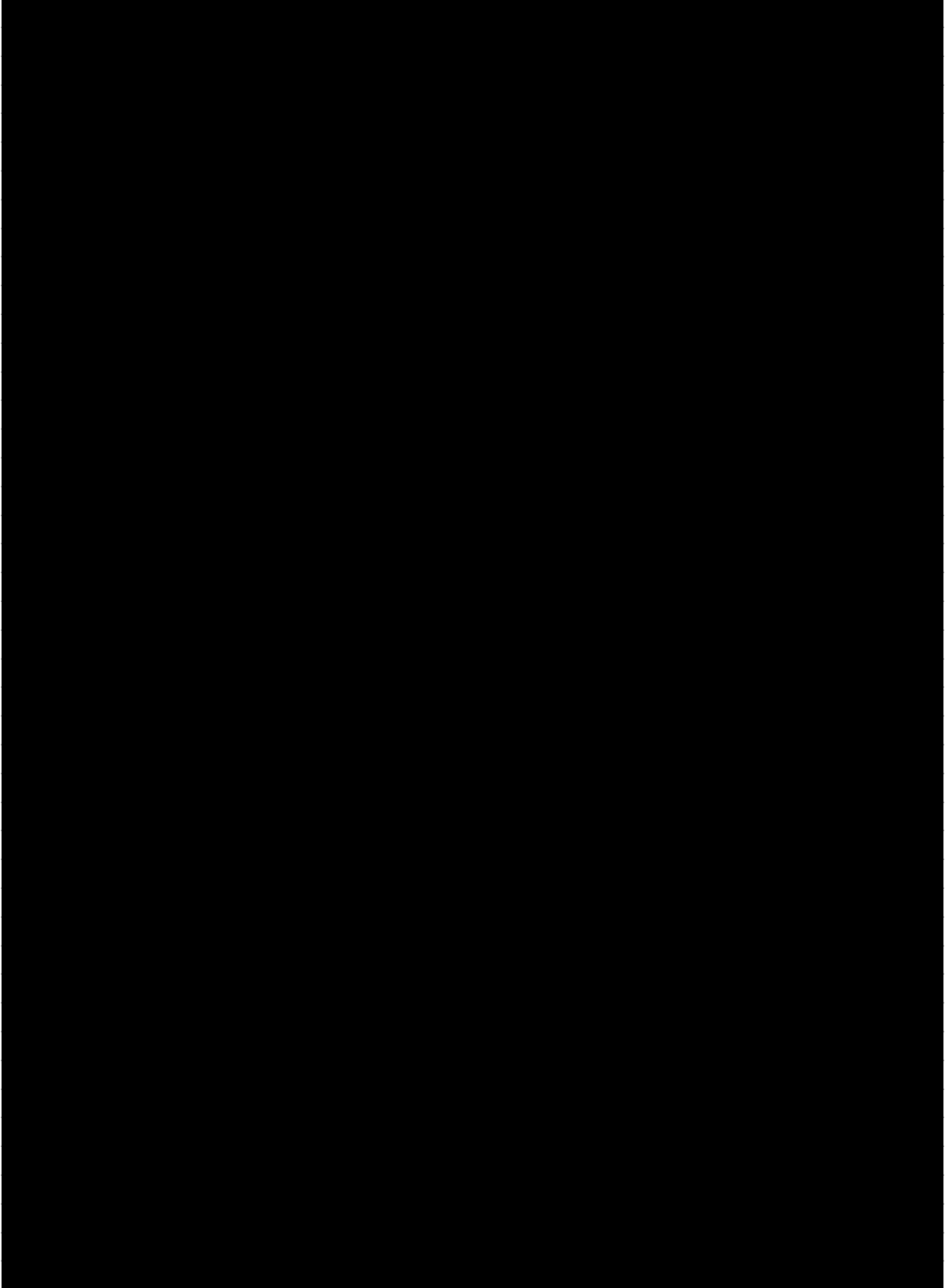
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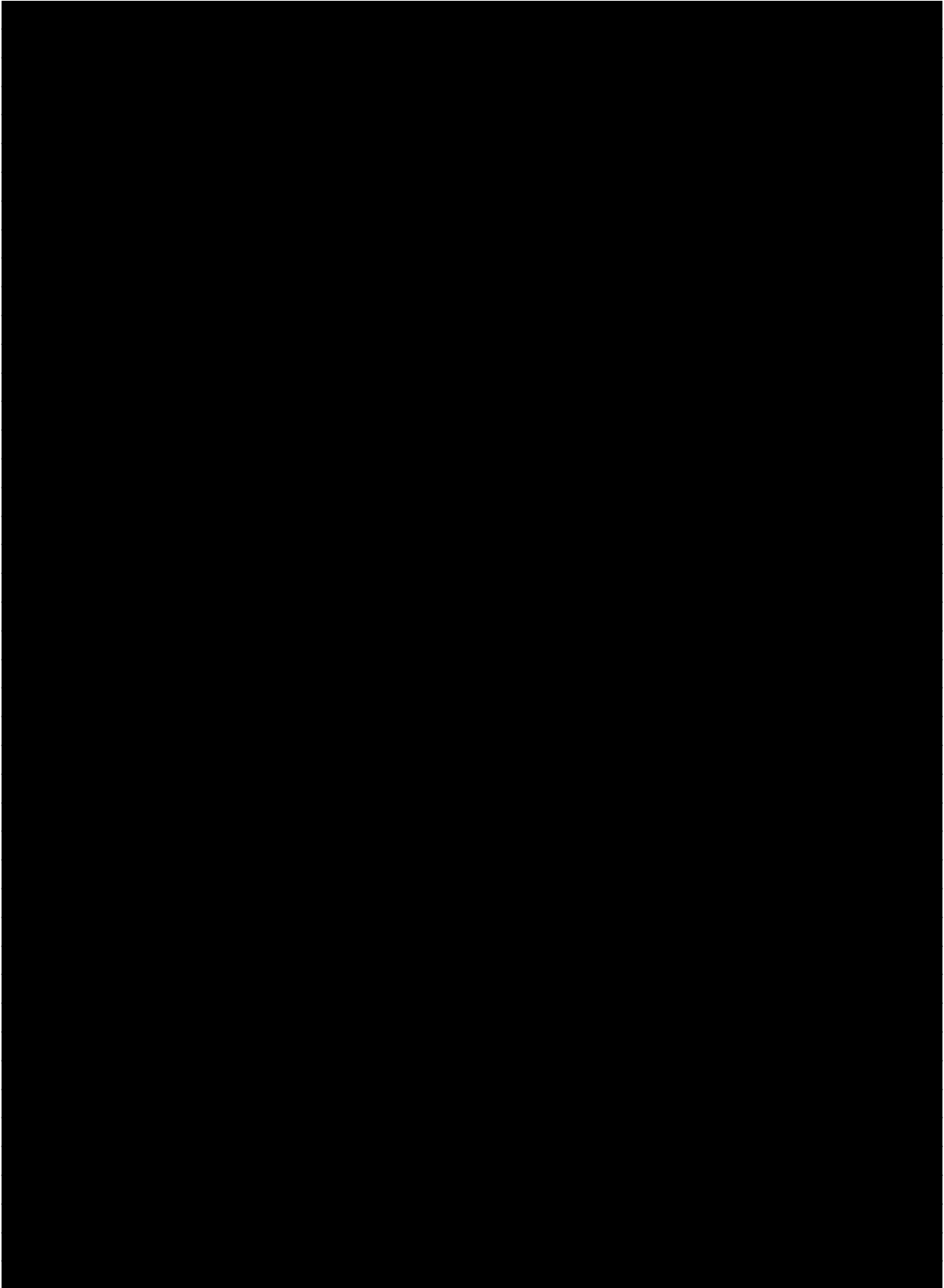
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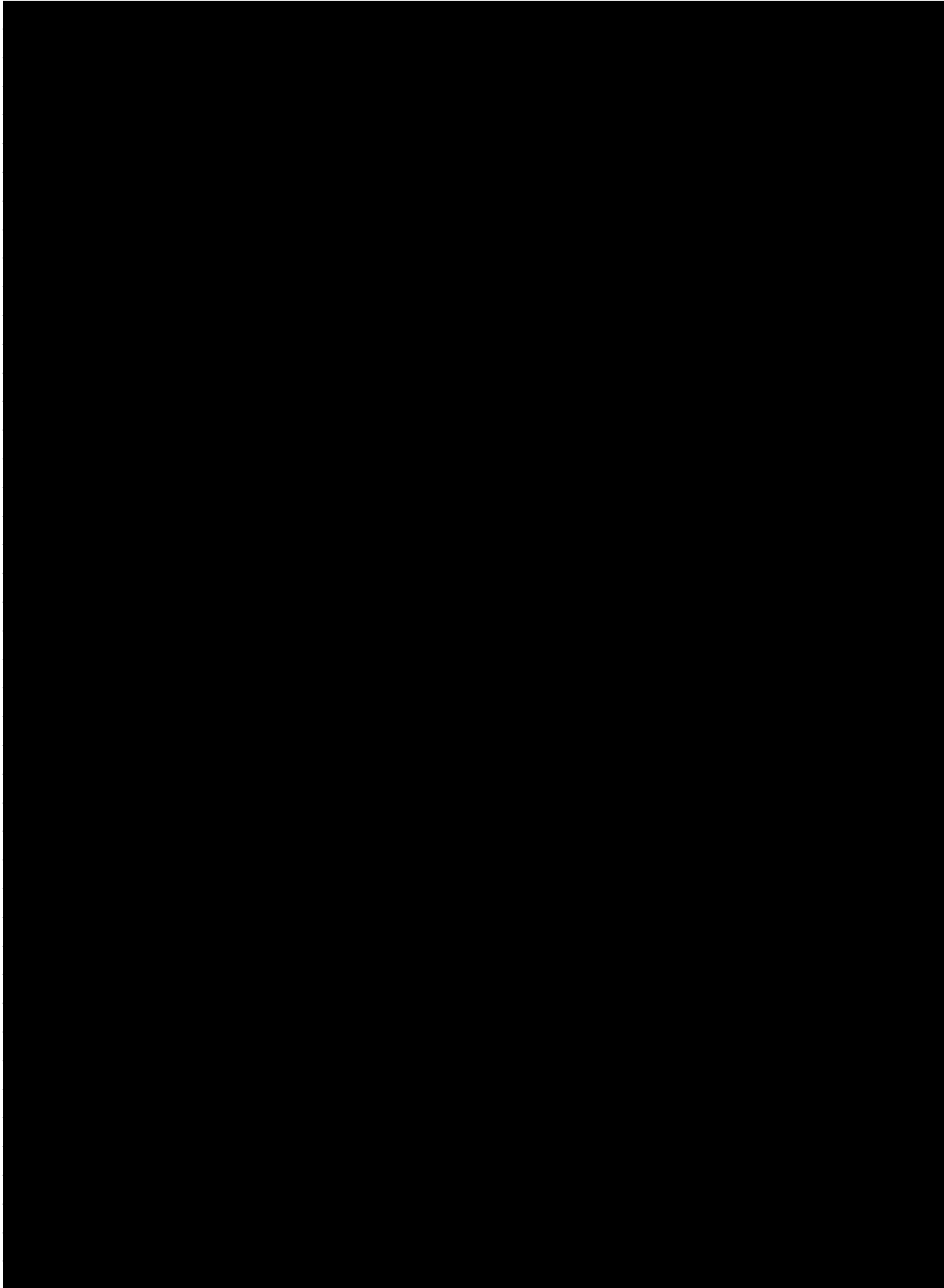
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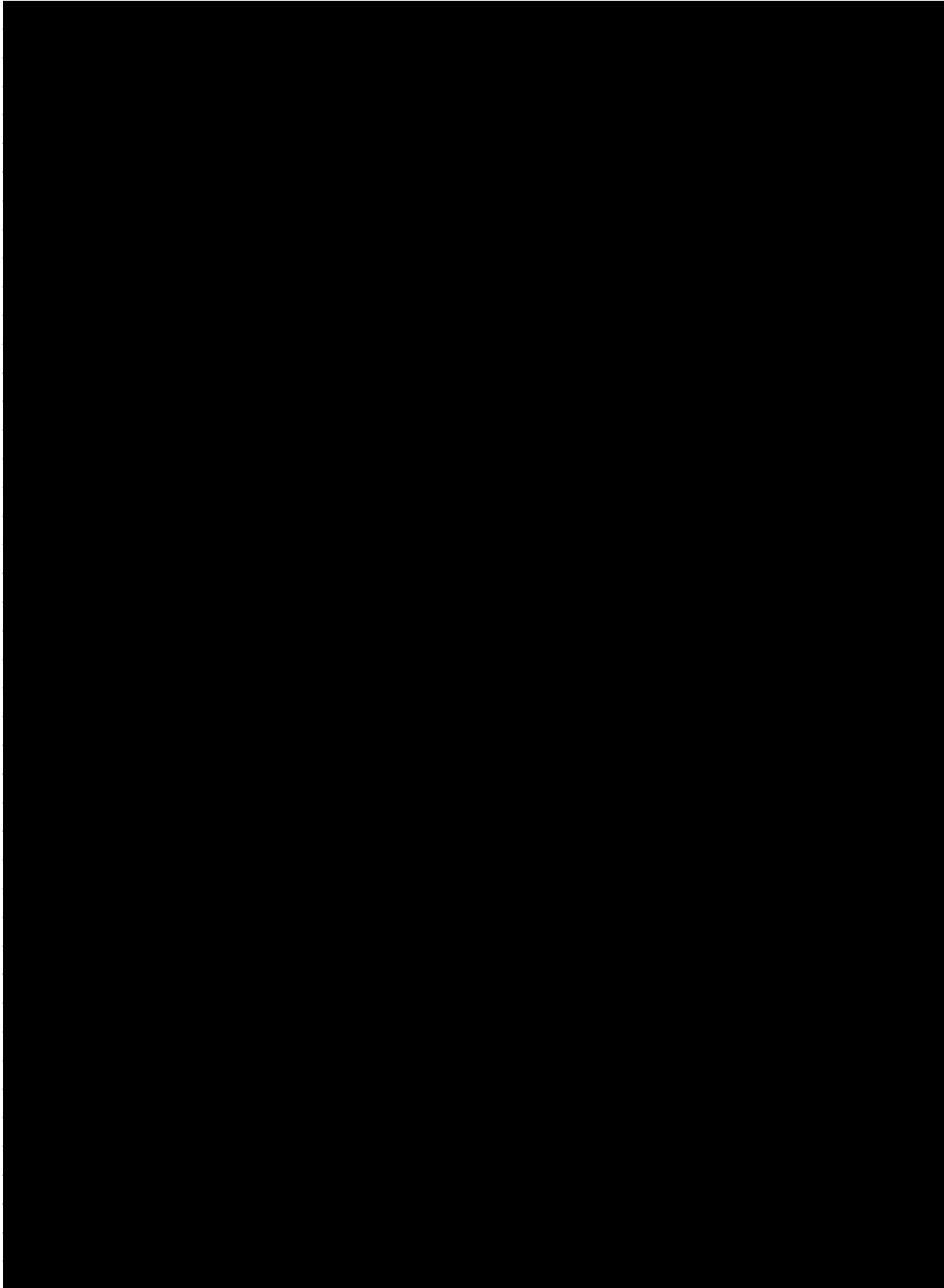
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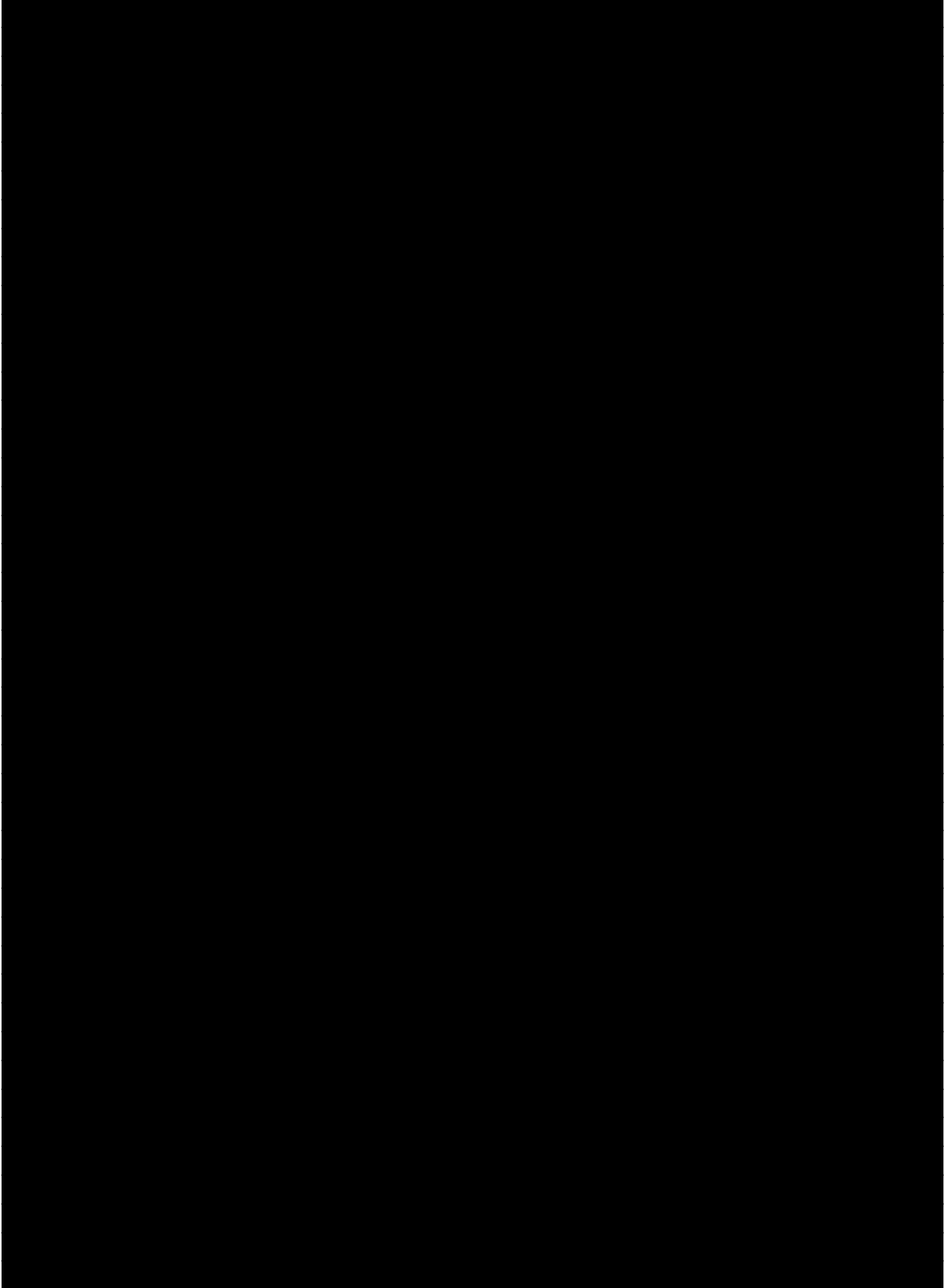


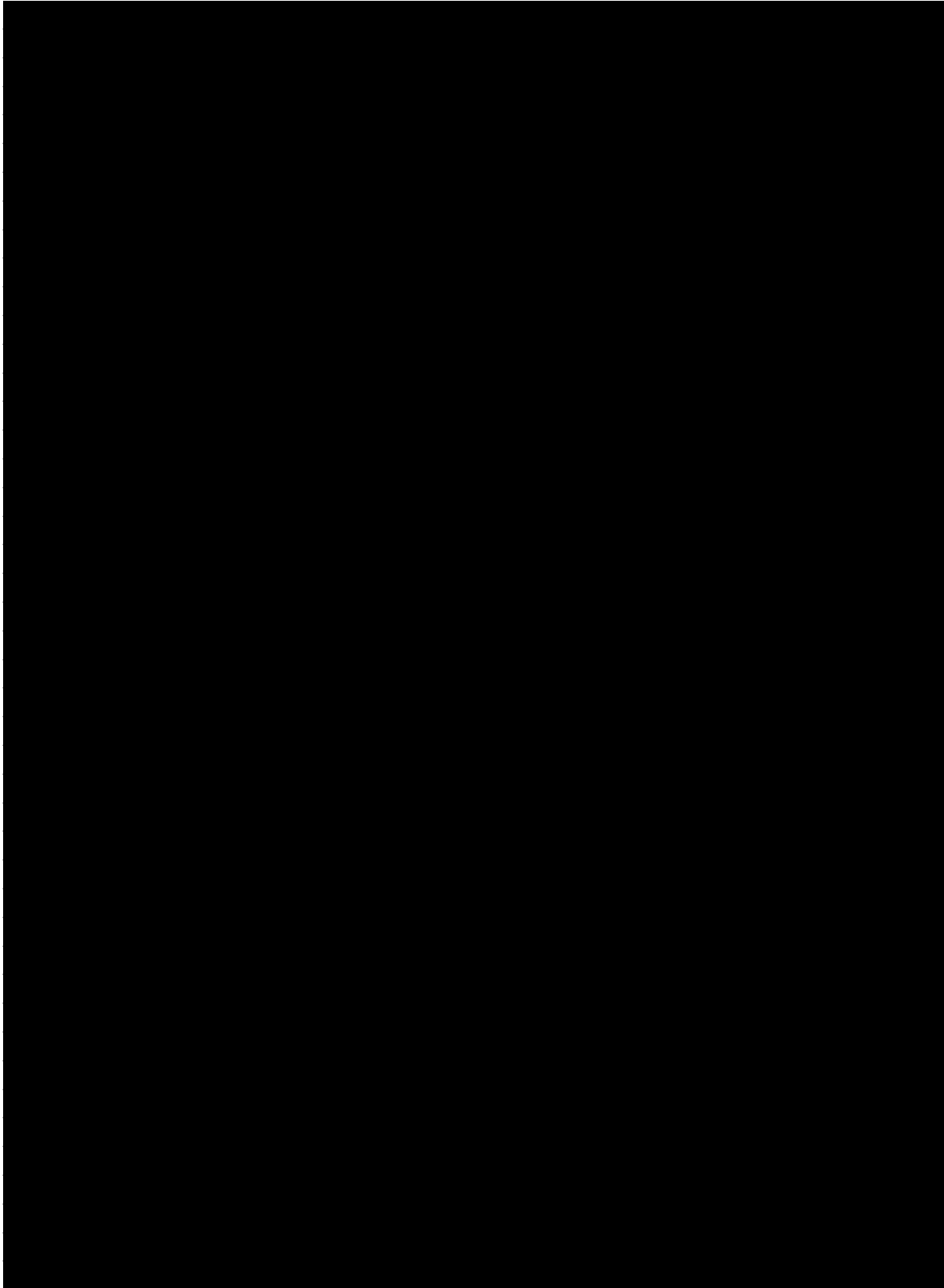


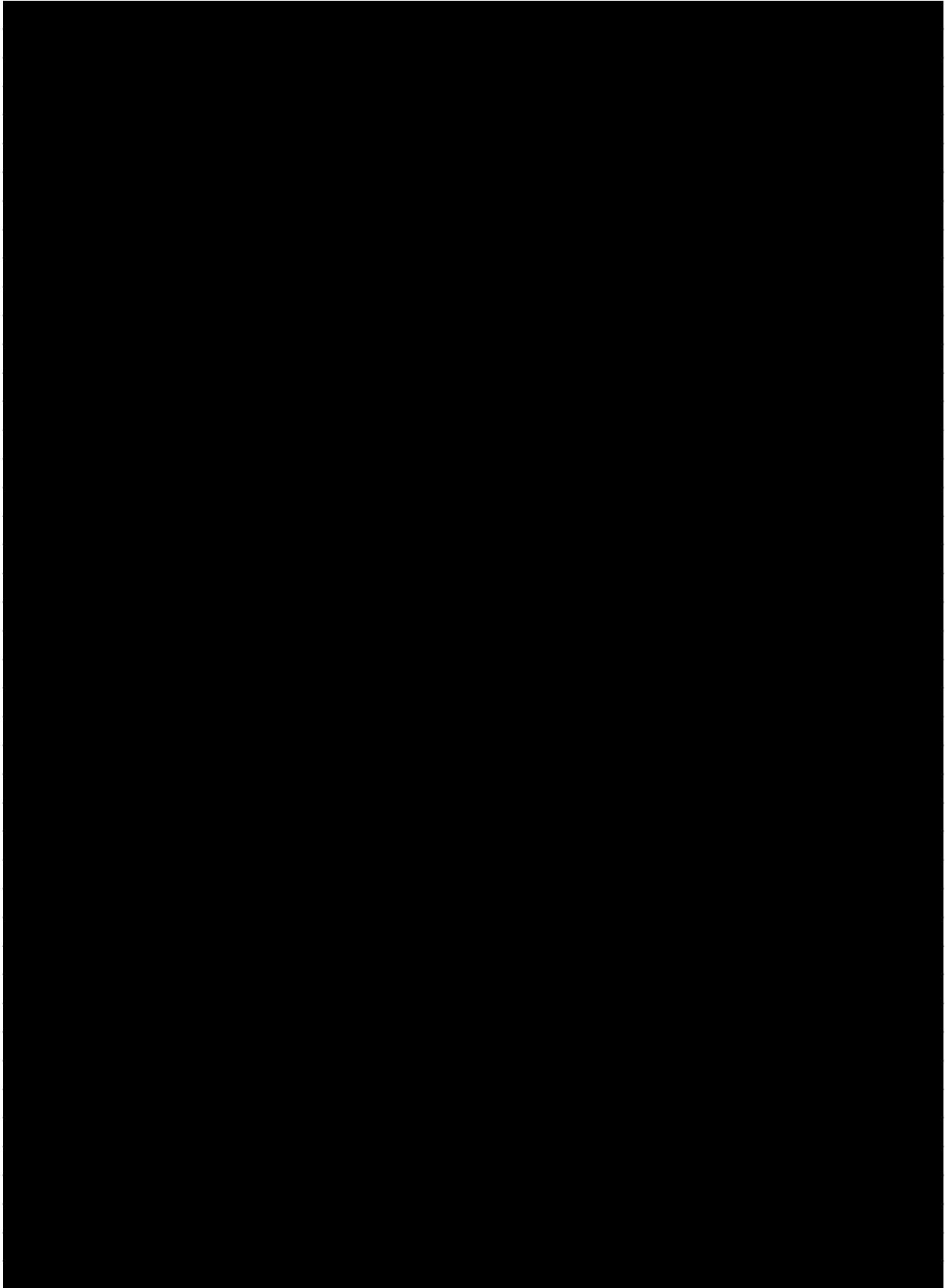
GIS 12 MA/026 provides as follows concerning the availability of 24 hour, split-shift personal care services in connection with the case of Strouchler v. Shah:

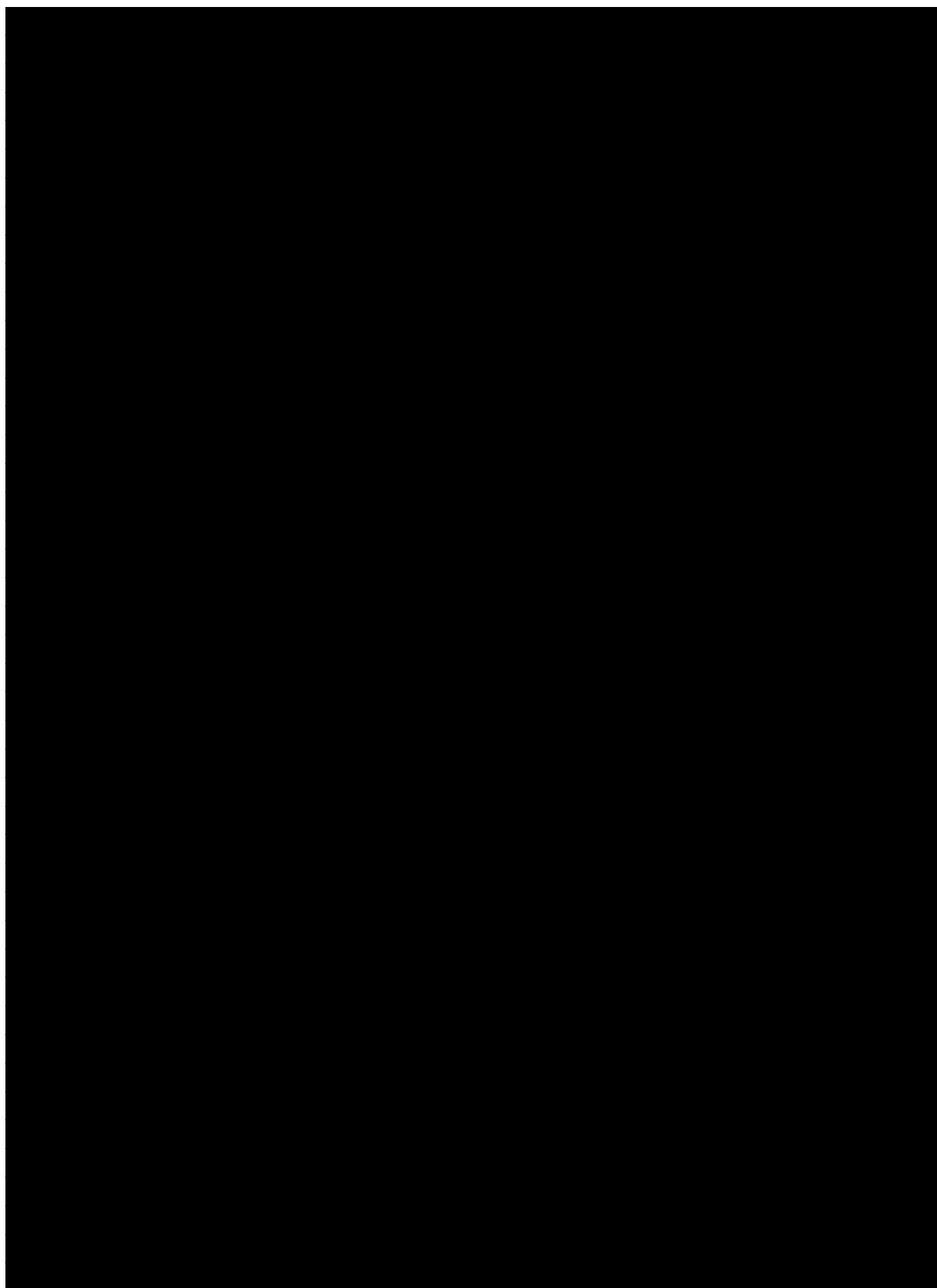


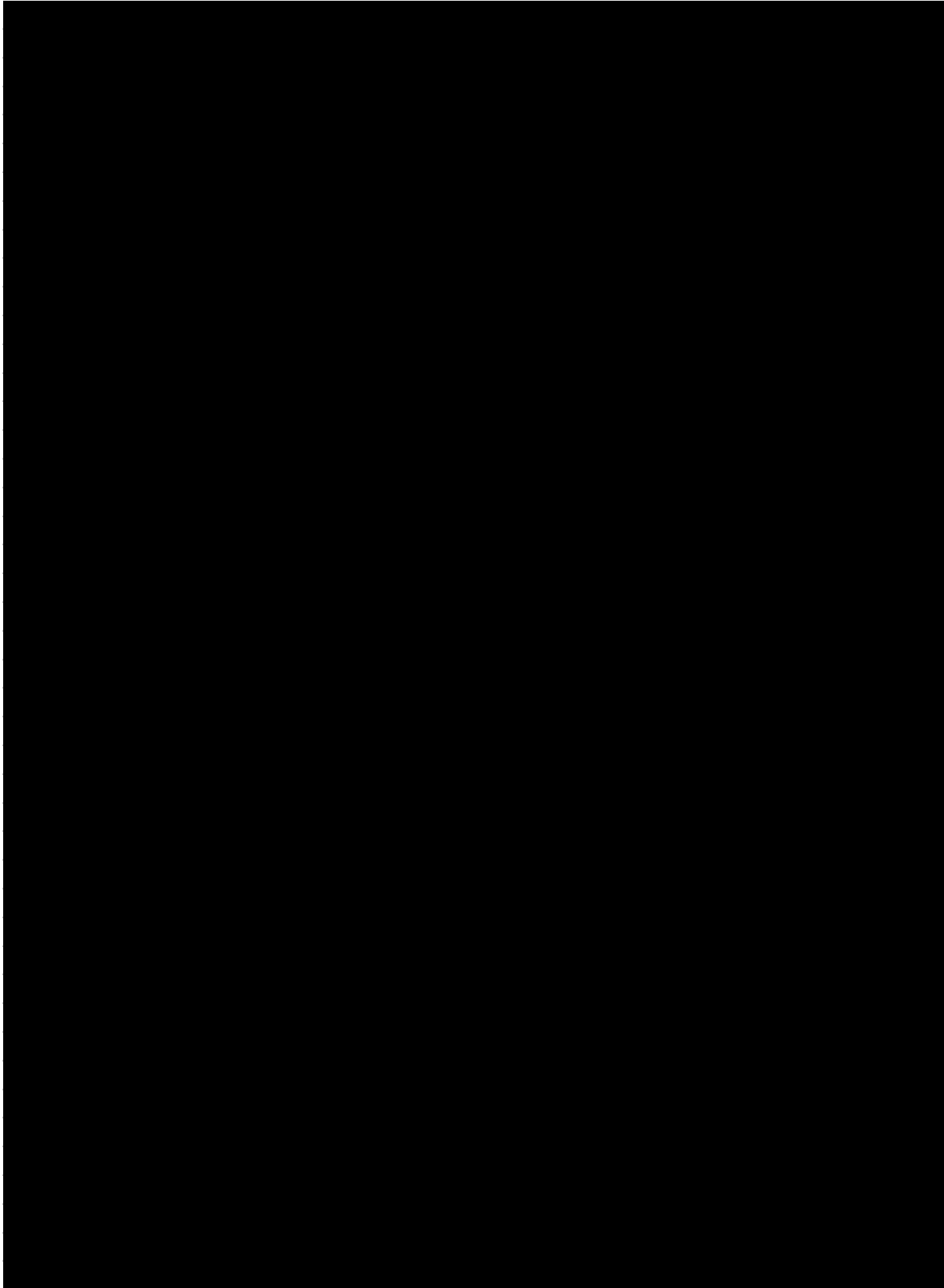




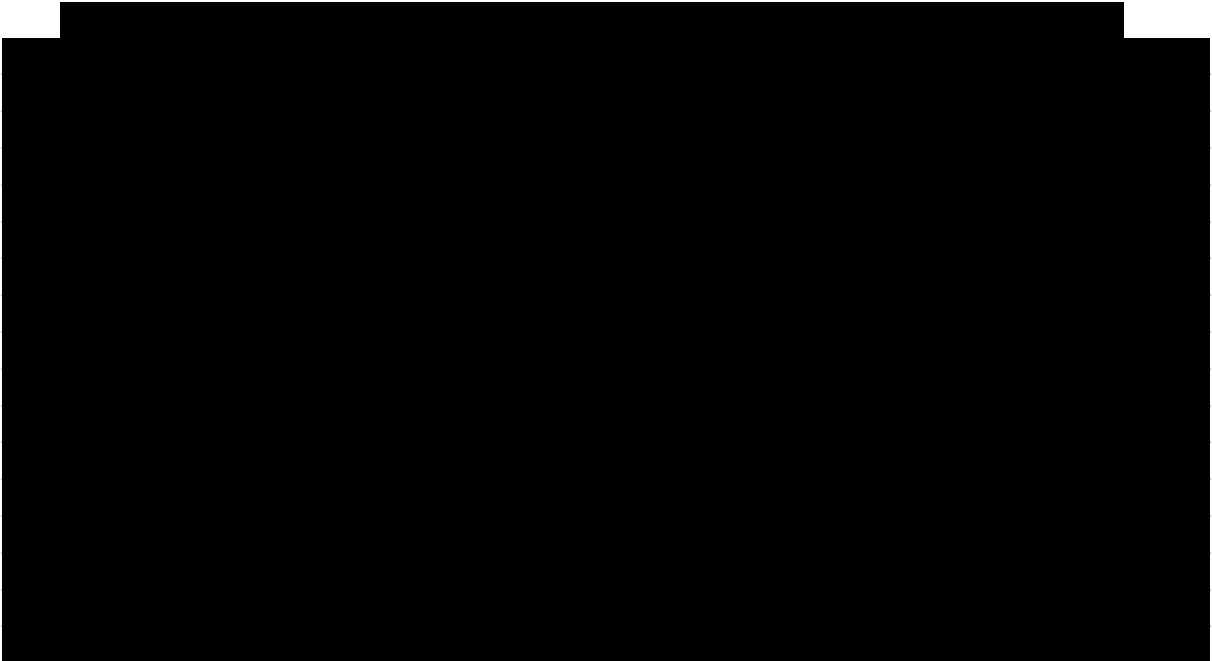


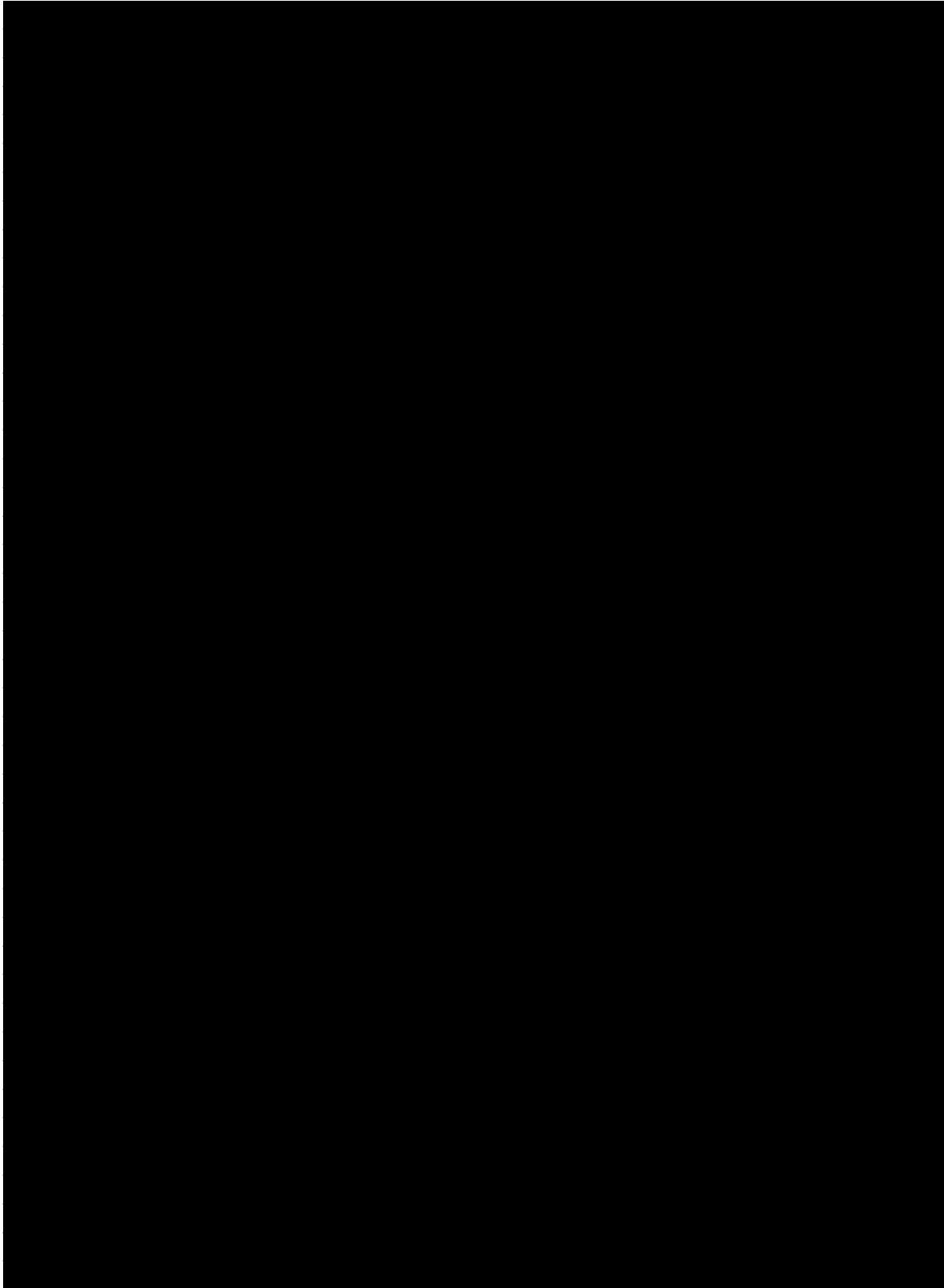




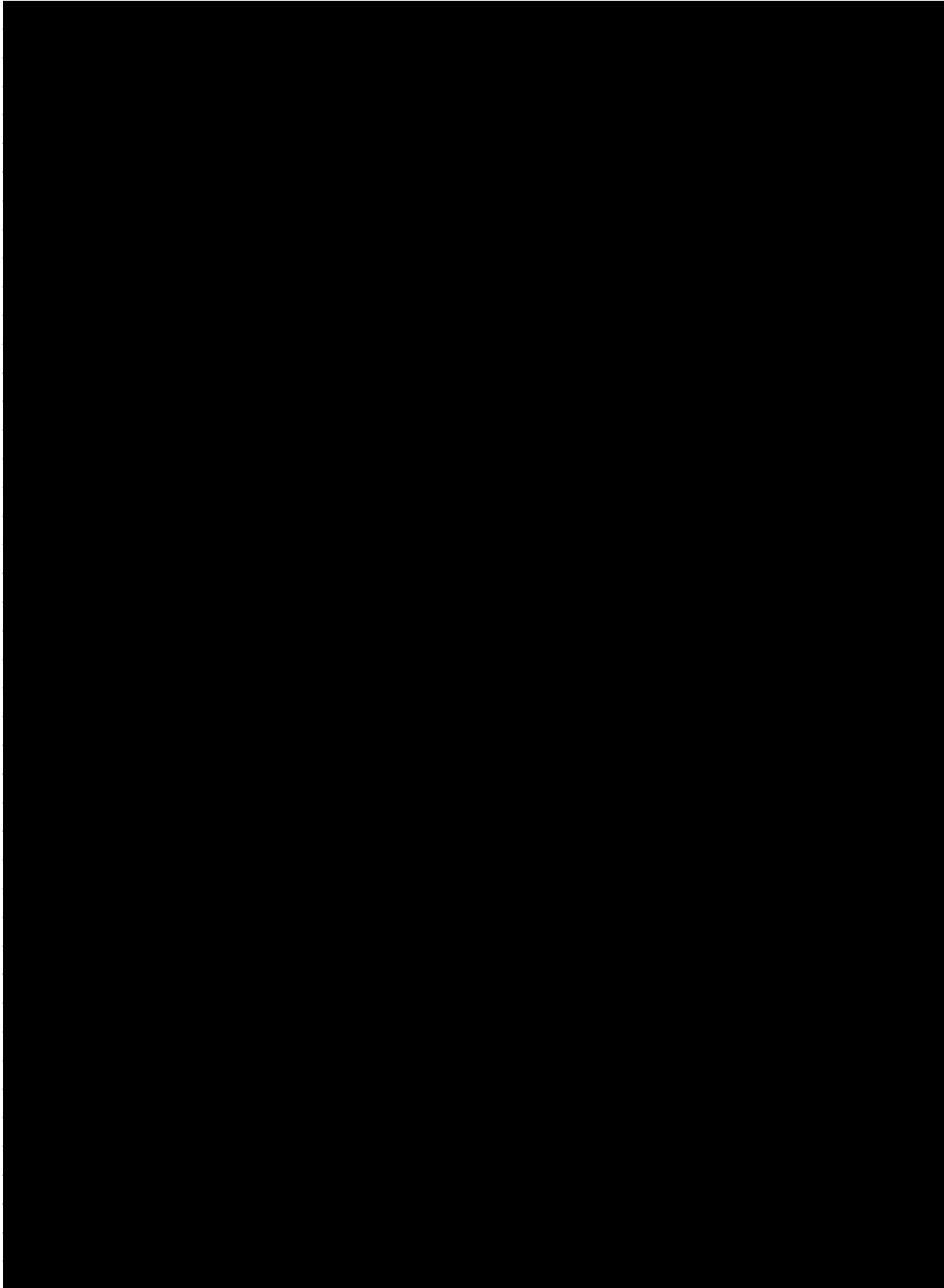


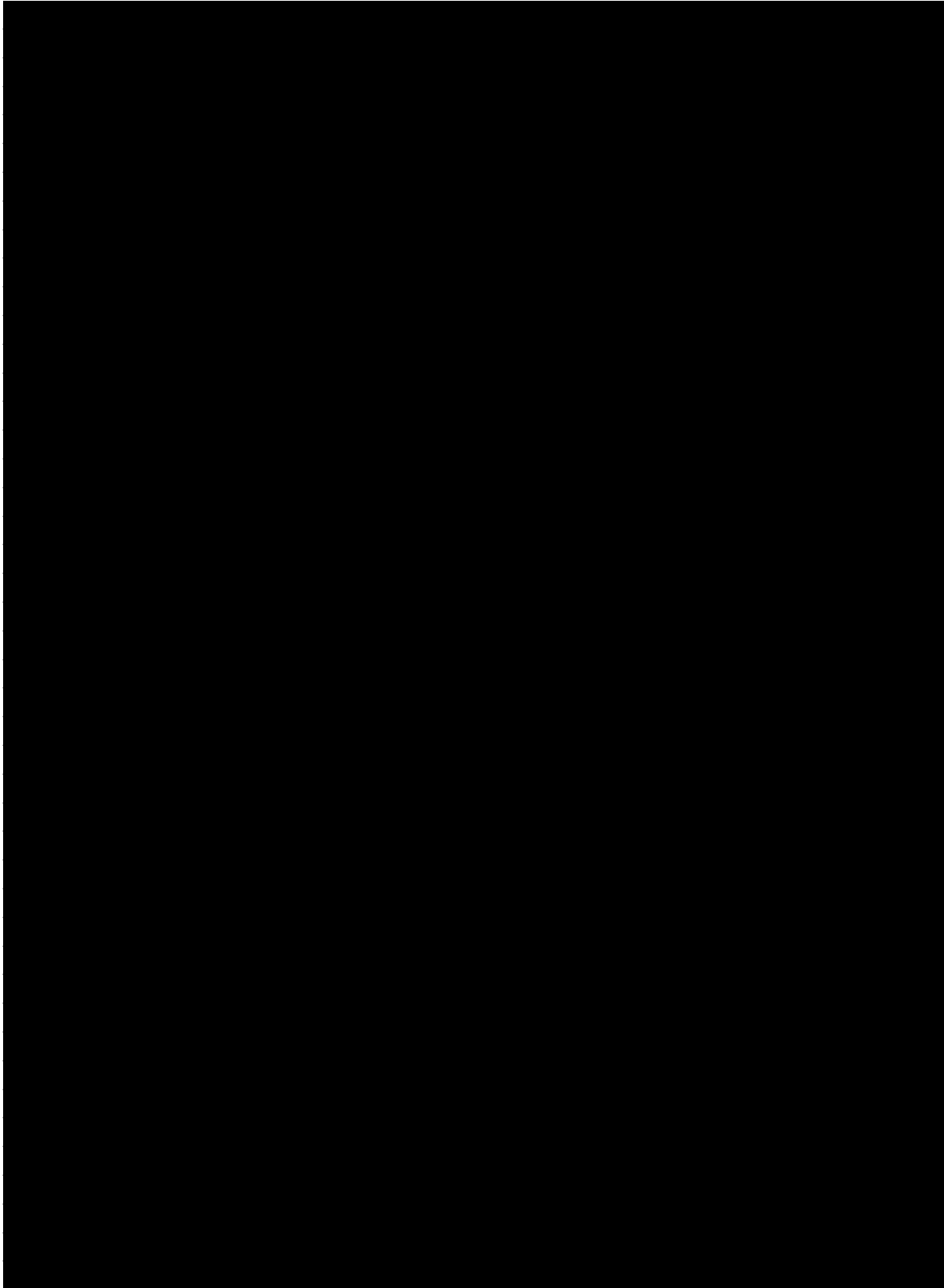
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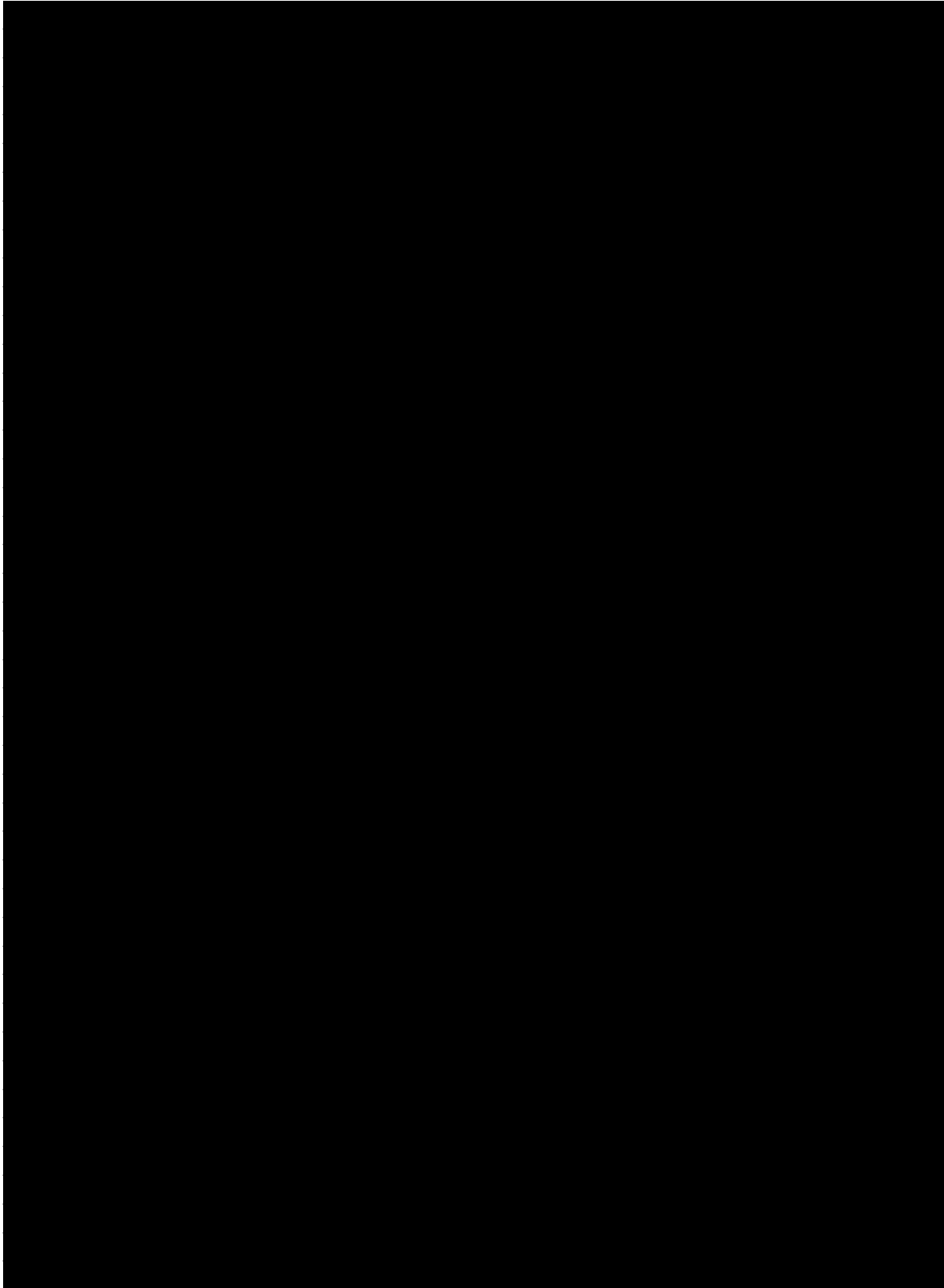


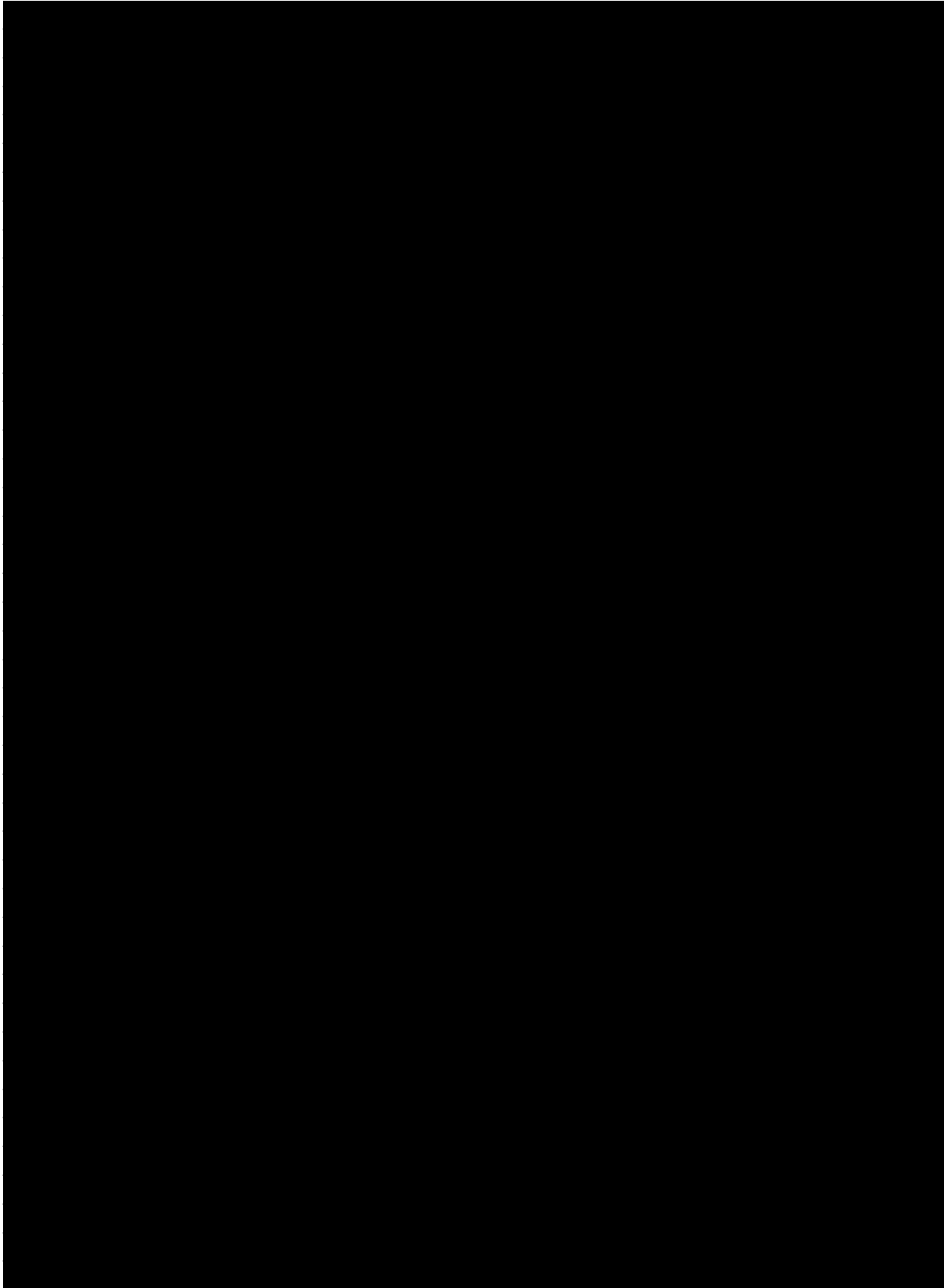


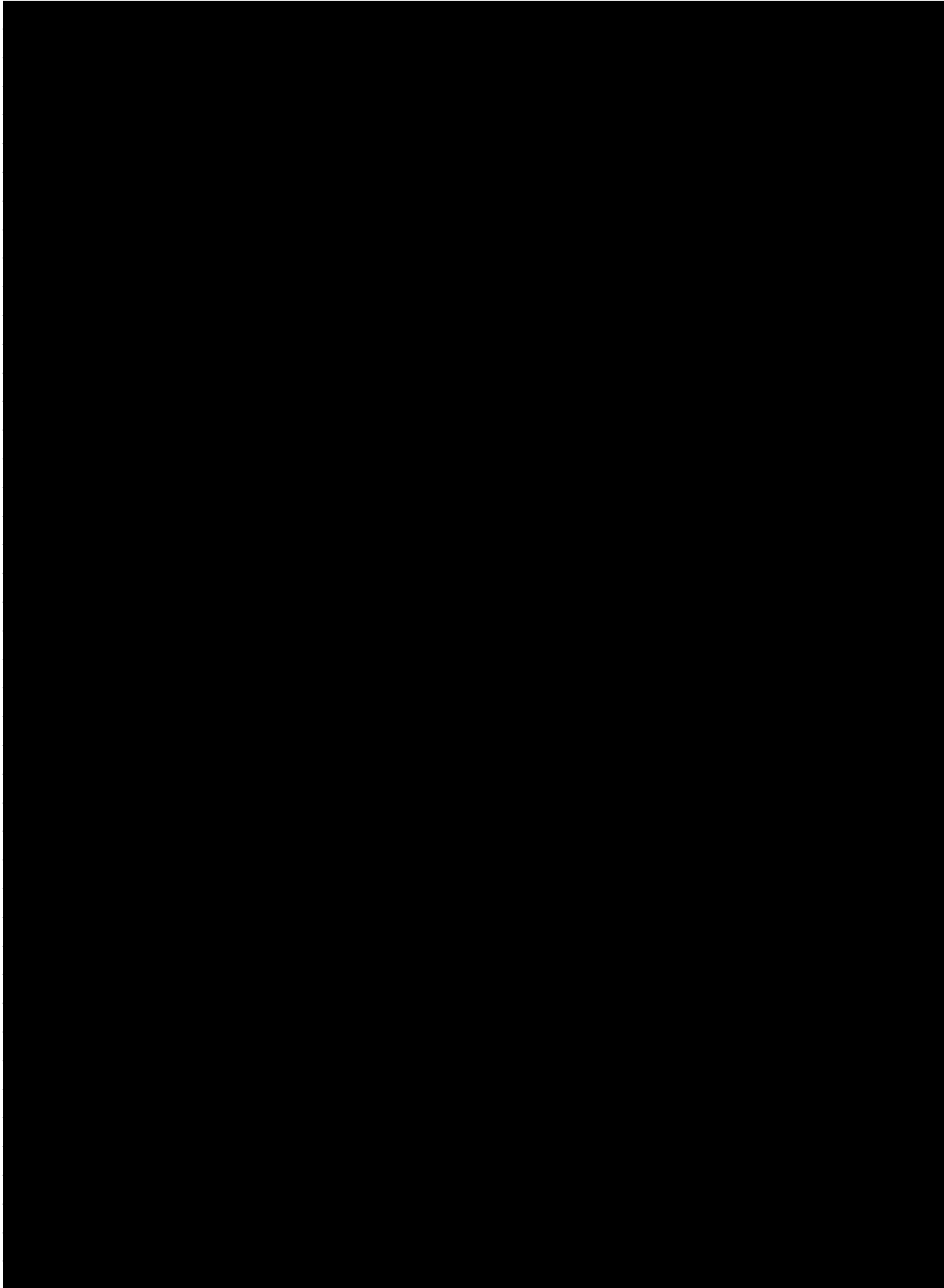
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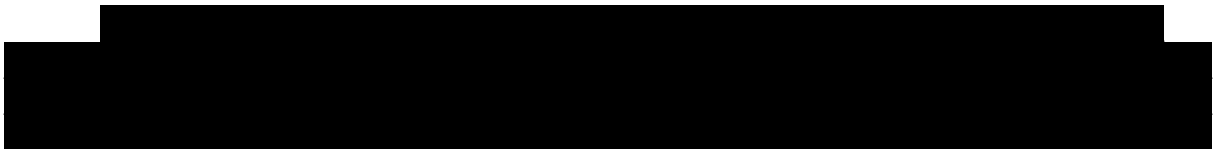
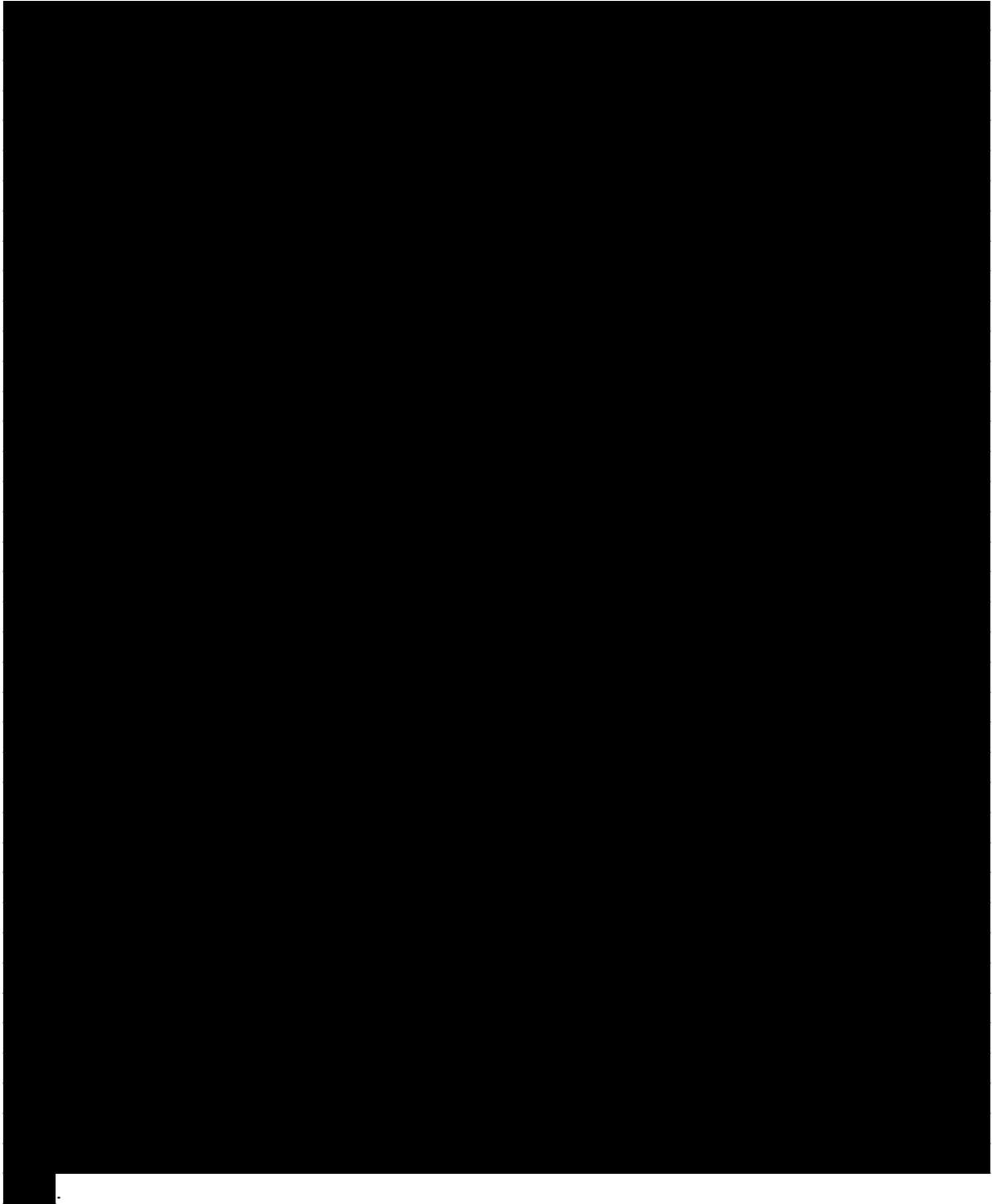


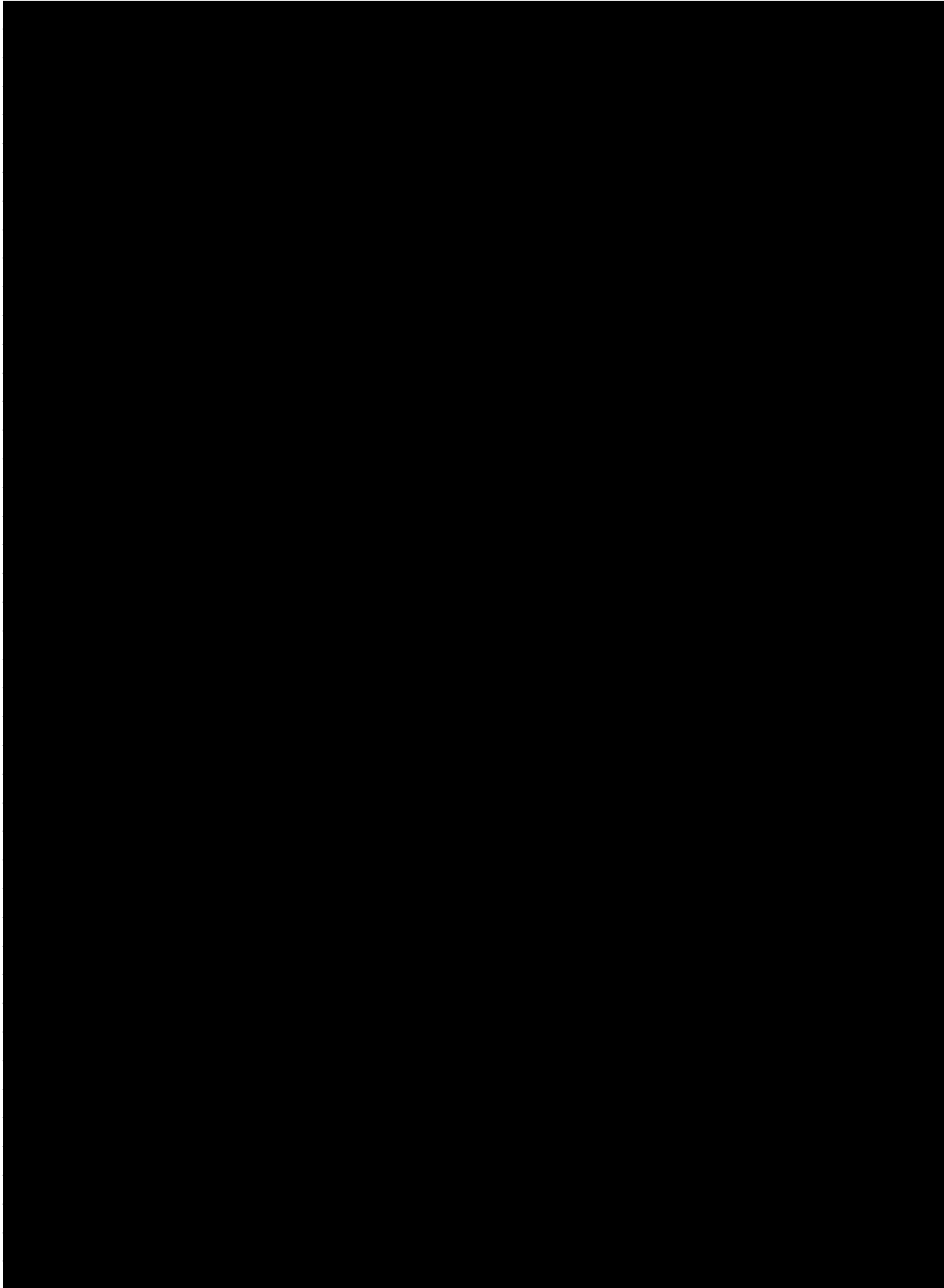


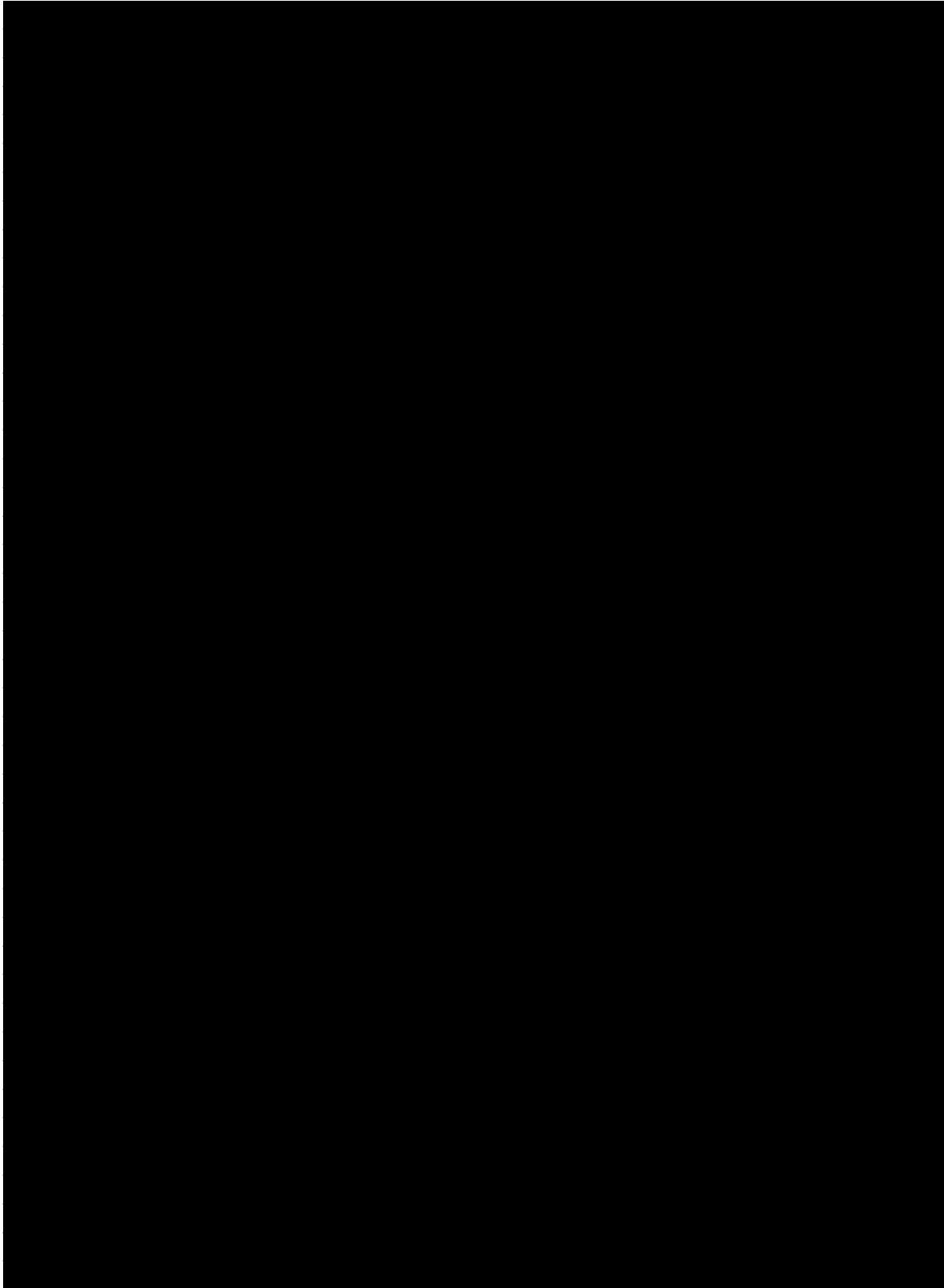




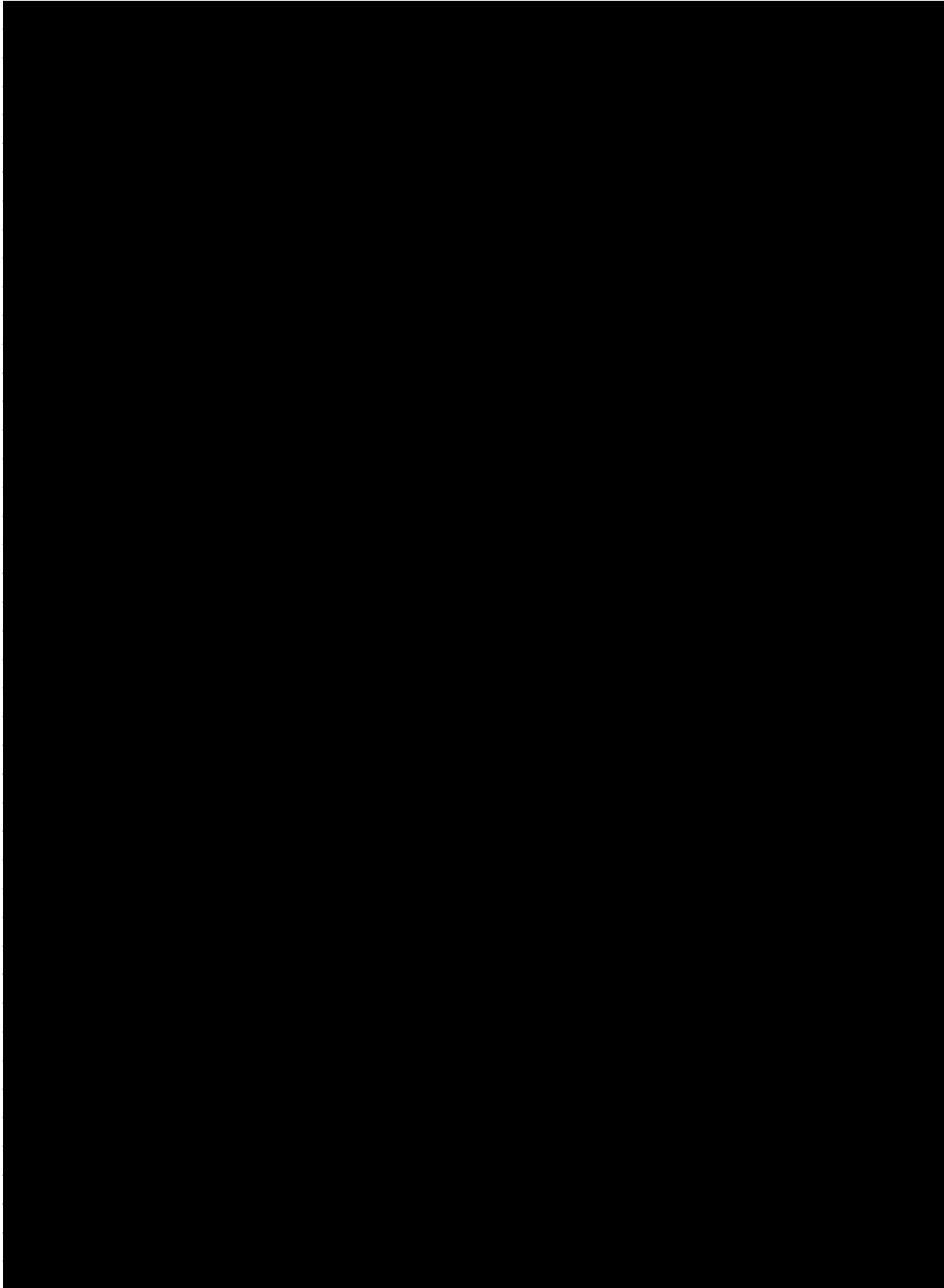
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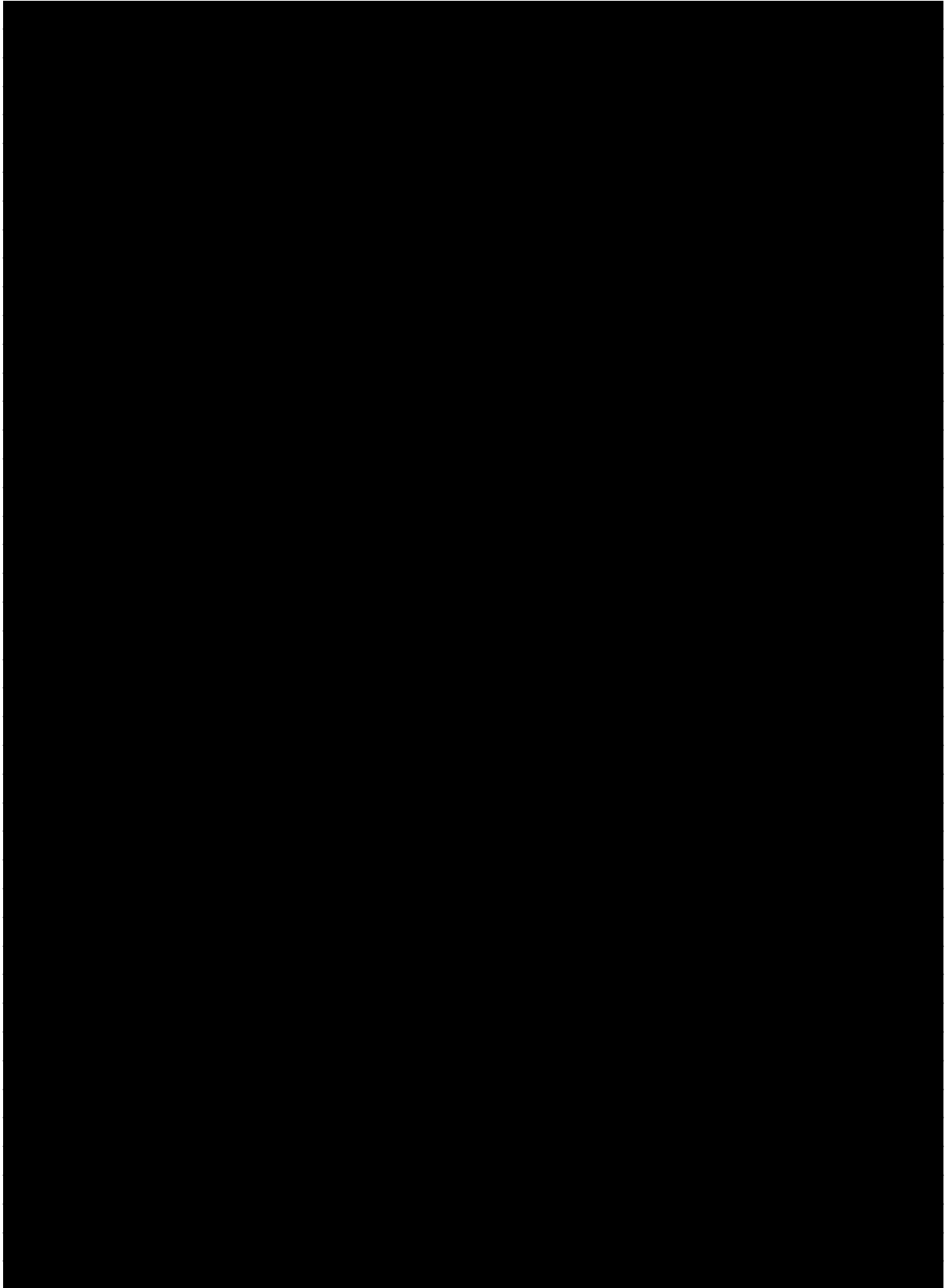




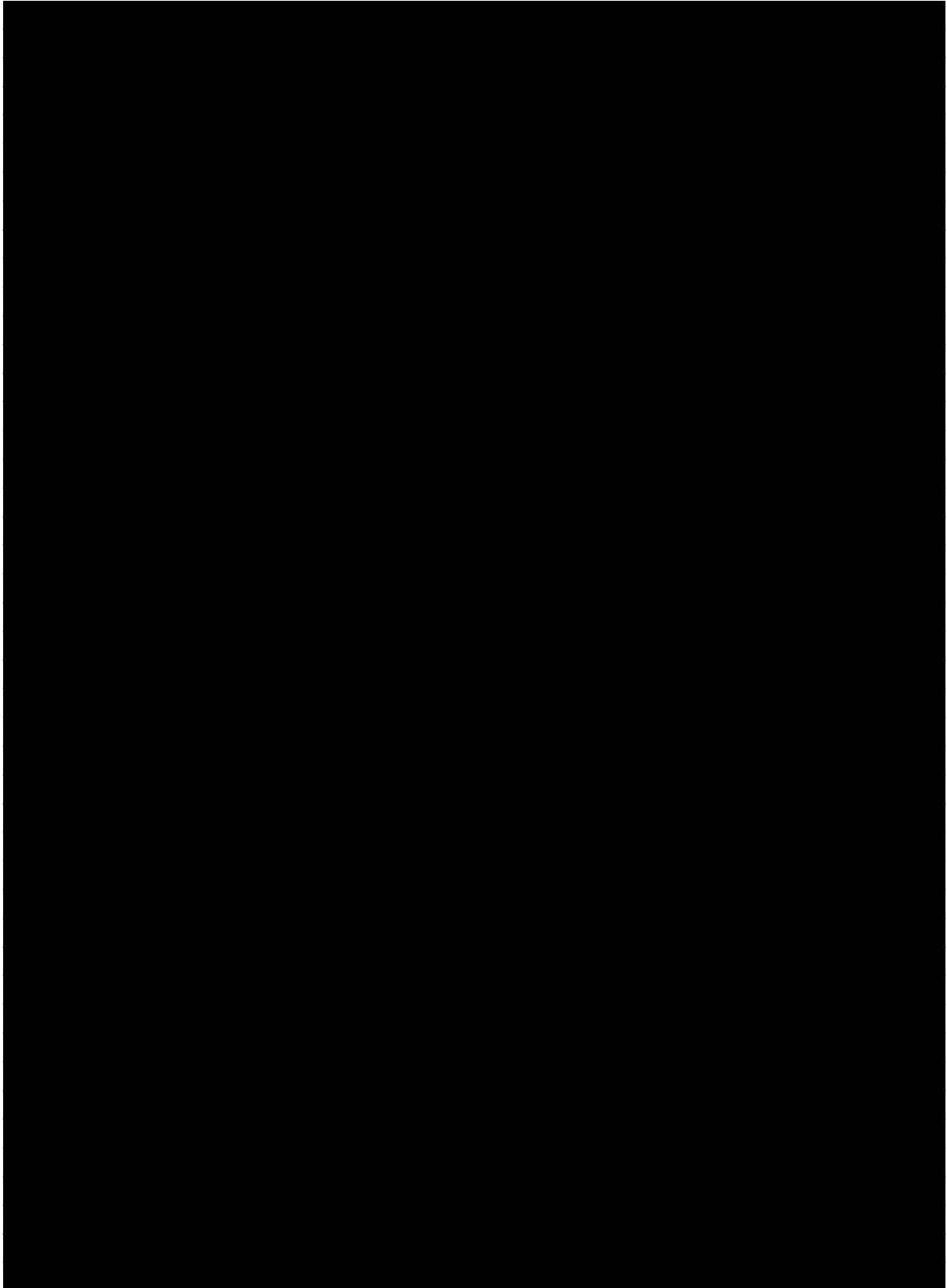


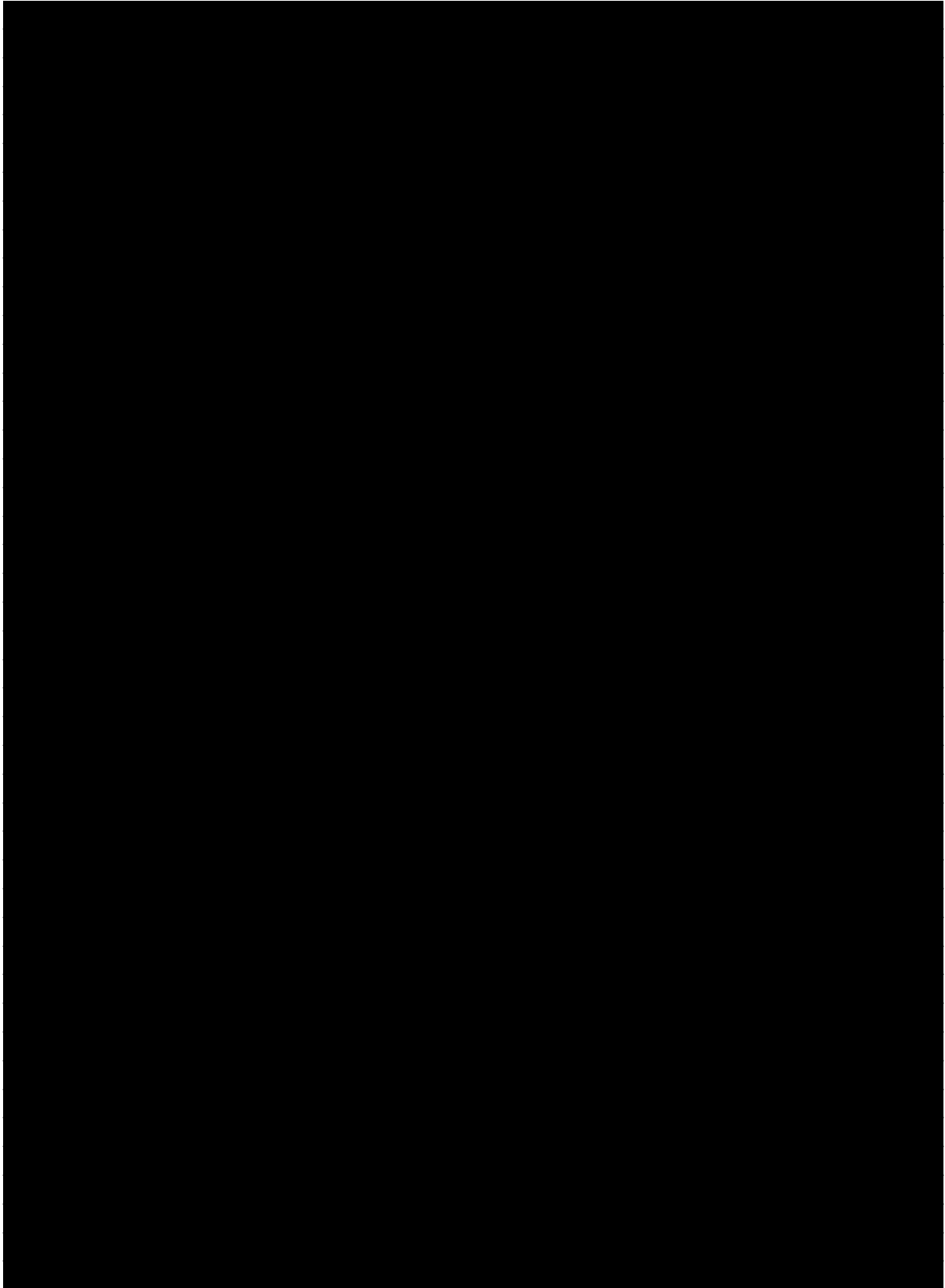
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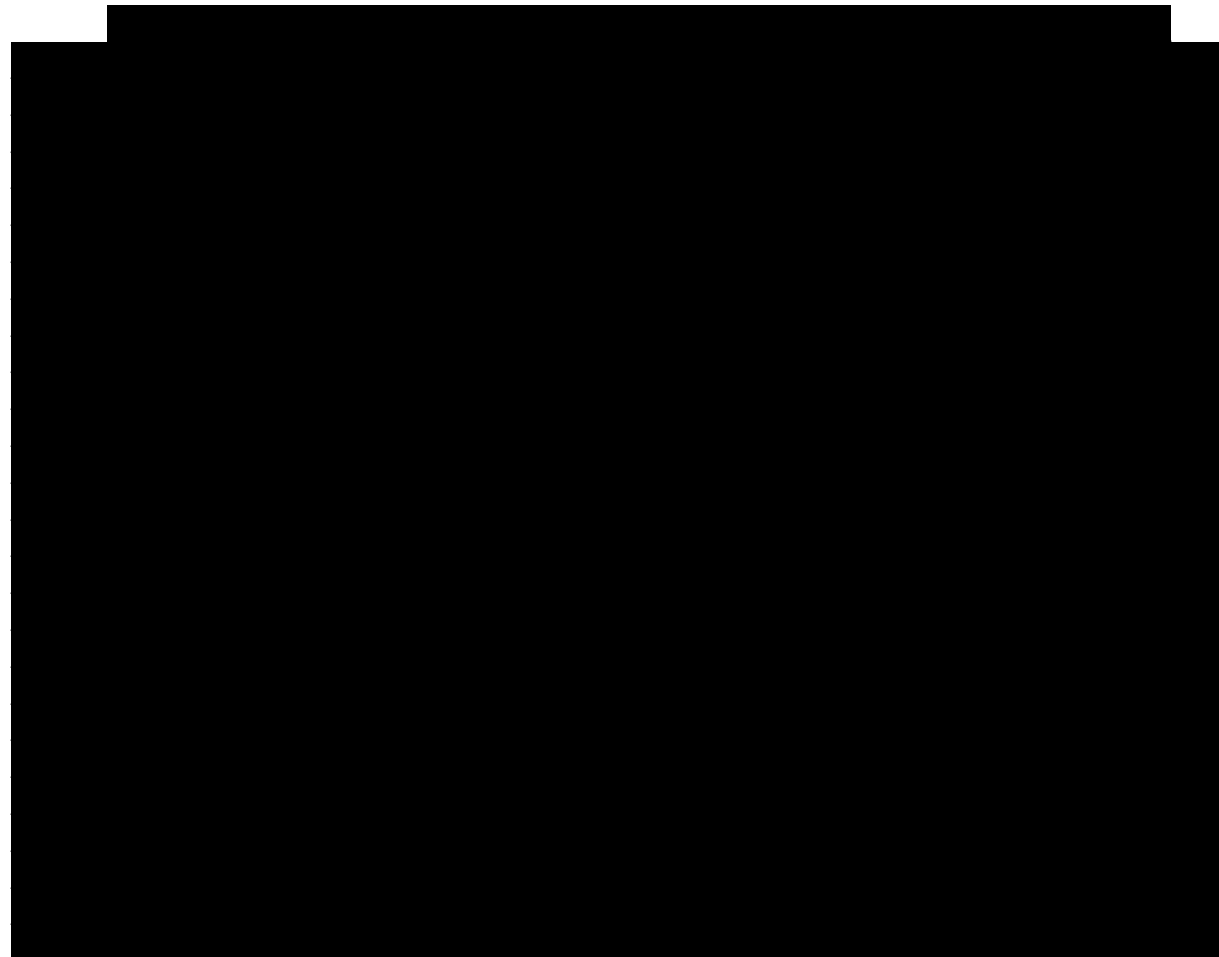


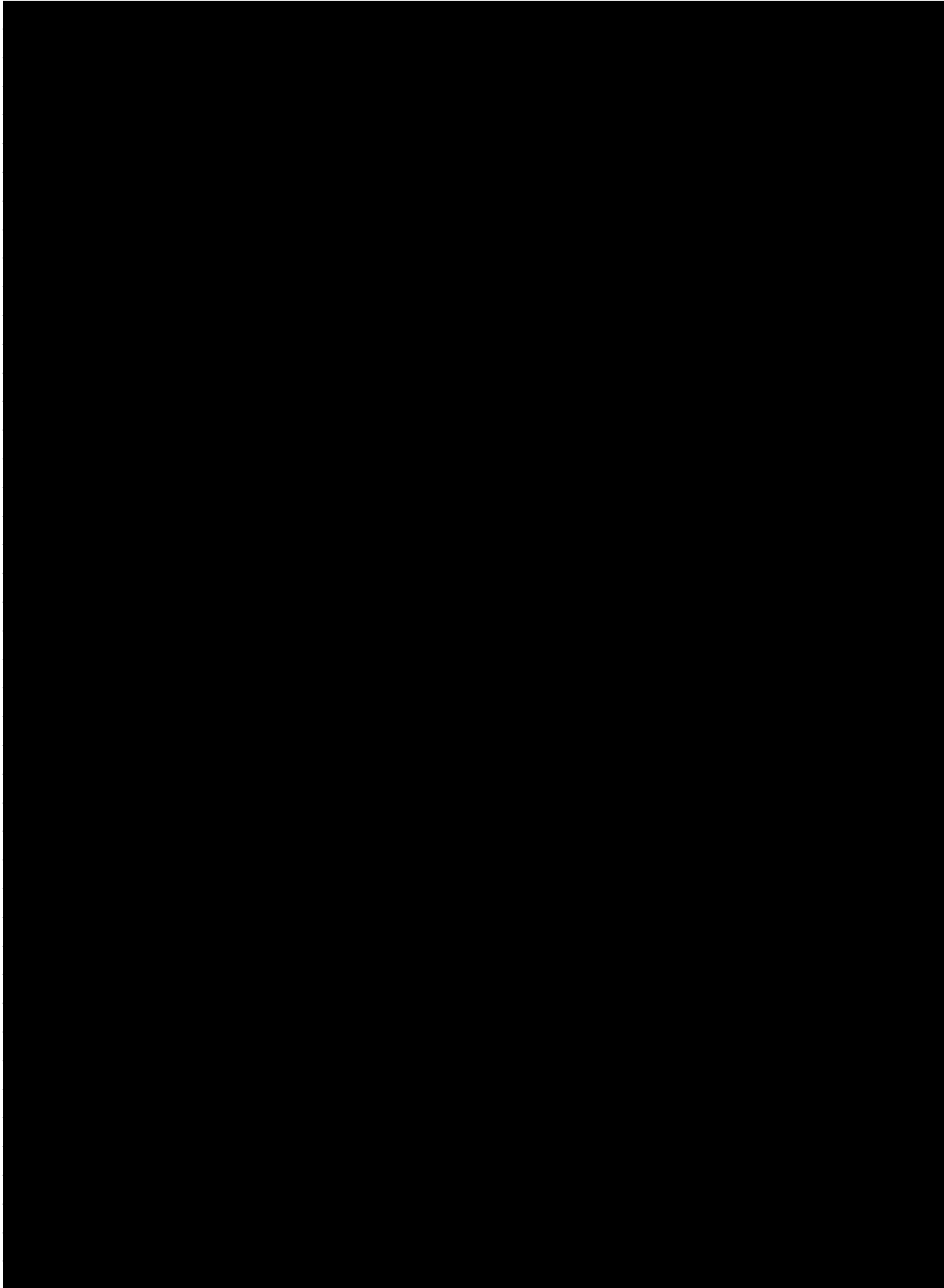


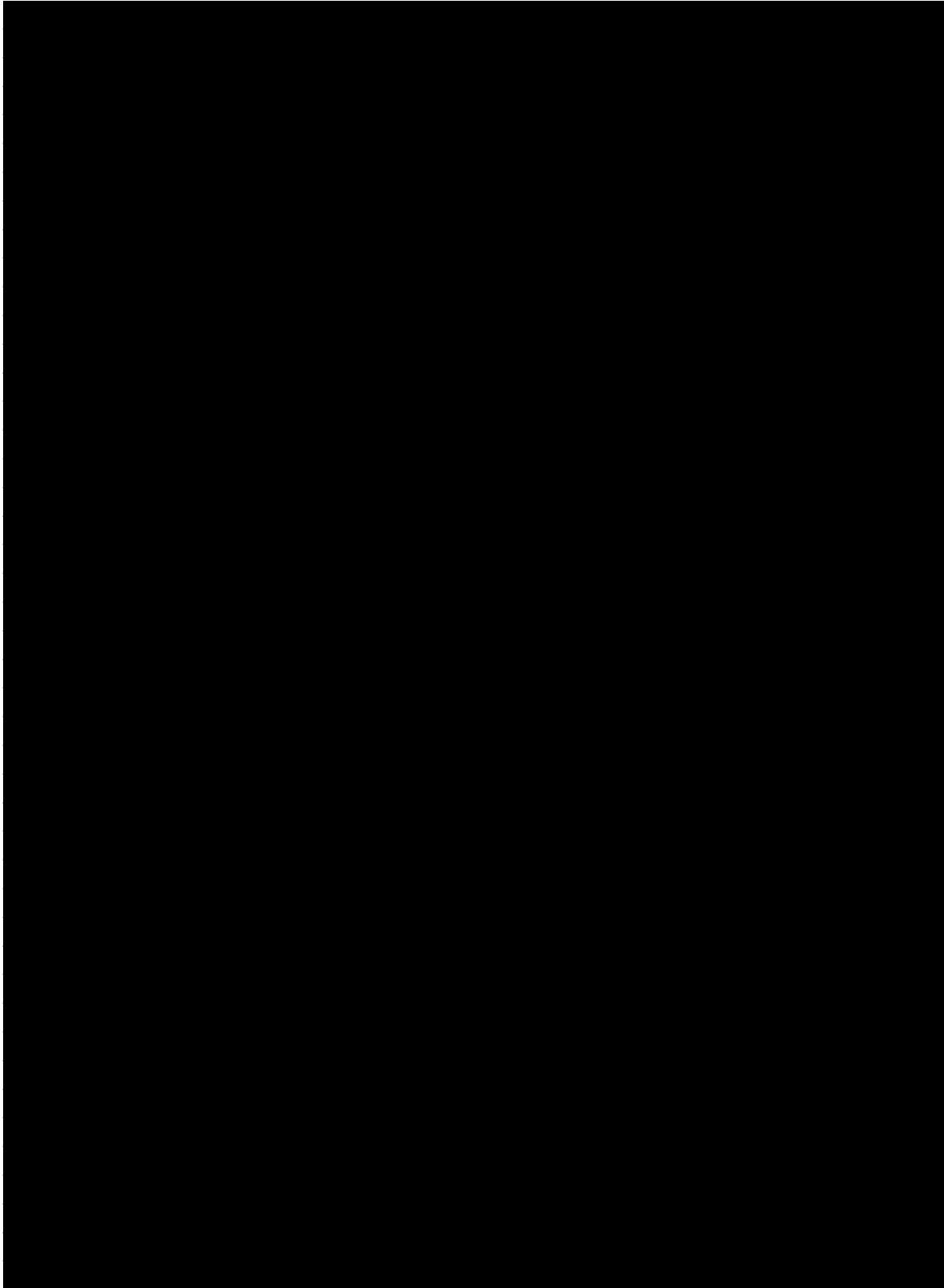


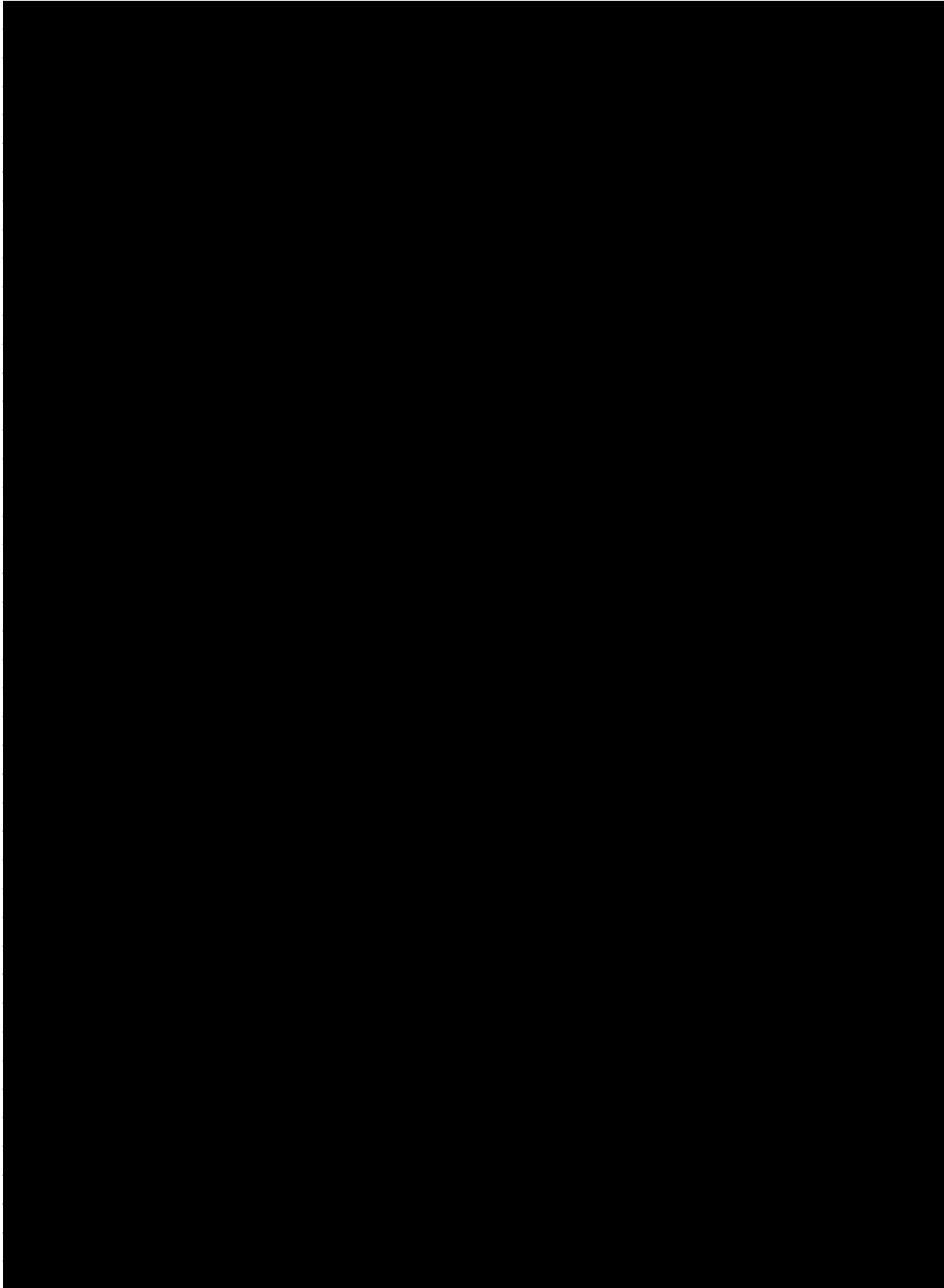


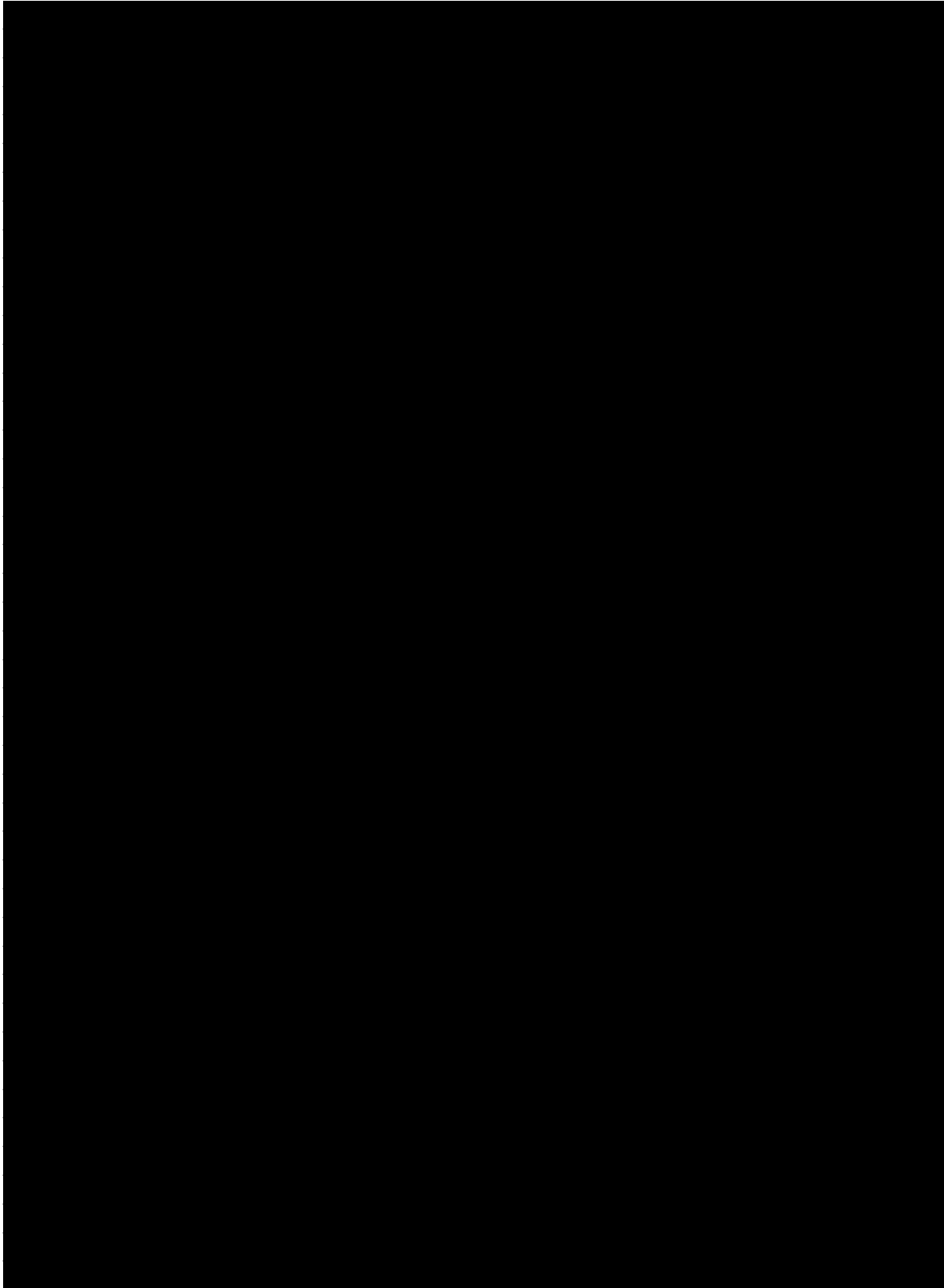
In Rodriguez v. City of New York, 197 F. 3rd 611 (Federal Court of Appeals, 2nd Circuit 1999), cert. denied 531 U.S. 864, the Plaintiffs were Personal Care Services recipients who alleged that they would be in receipt of inadequate service not meeting legal requirements, without the provision of safety monitoring as an independent task in their Personal Care Services authorizations. The district court had ruled in favor of the Plaintiffs, but the Court of Appeals held that the Agency is not required to provide safety monitoring as an independent Personal Care Services task in evaluating the needs of applicants for and recipients of Personal Care Services. Local Agencies were advised of this decision in GIS message 99/MA/036.

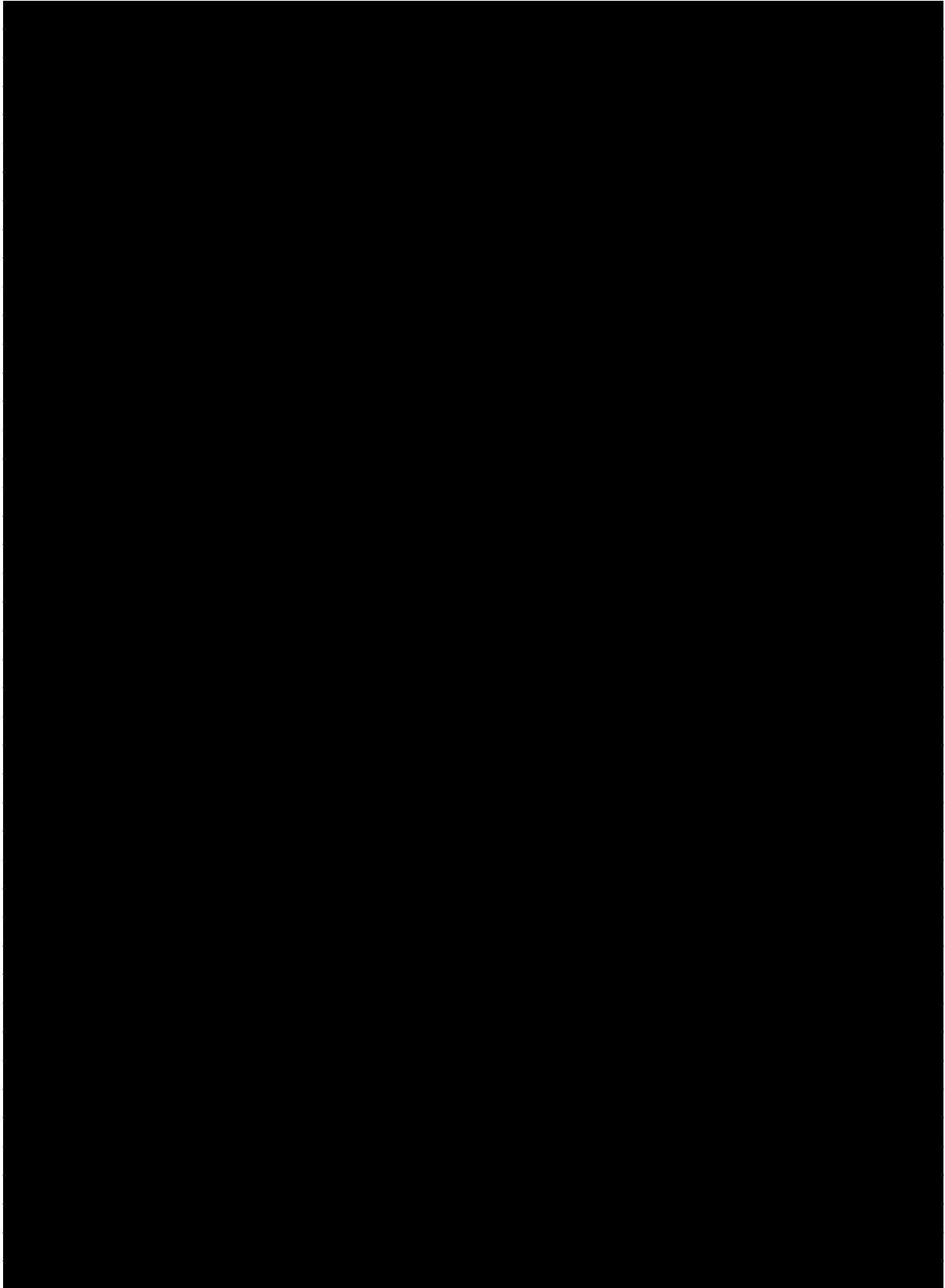


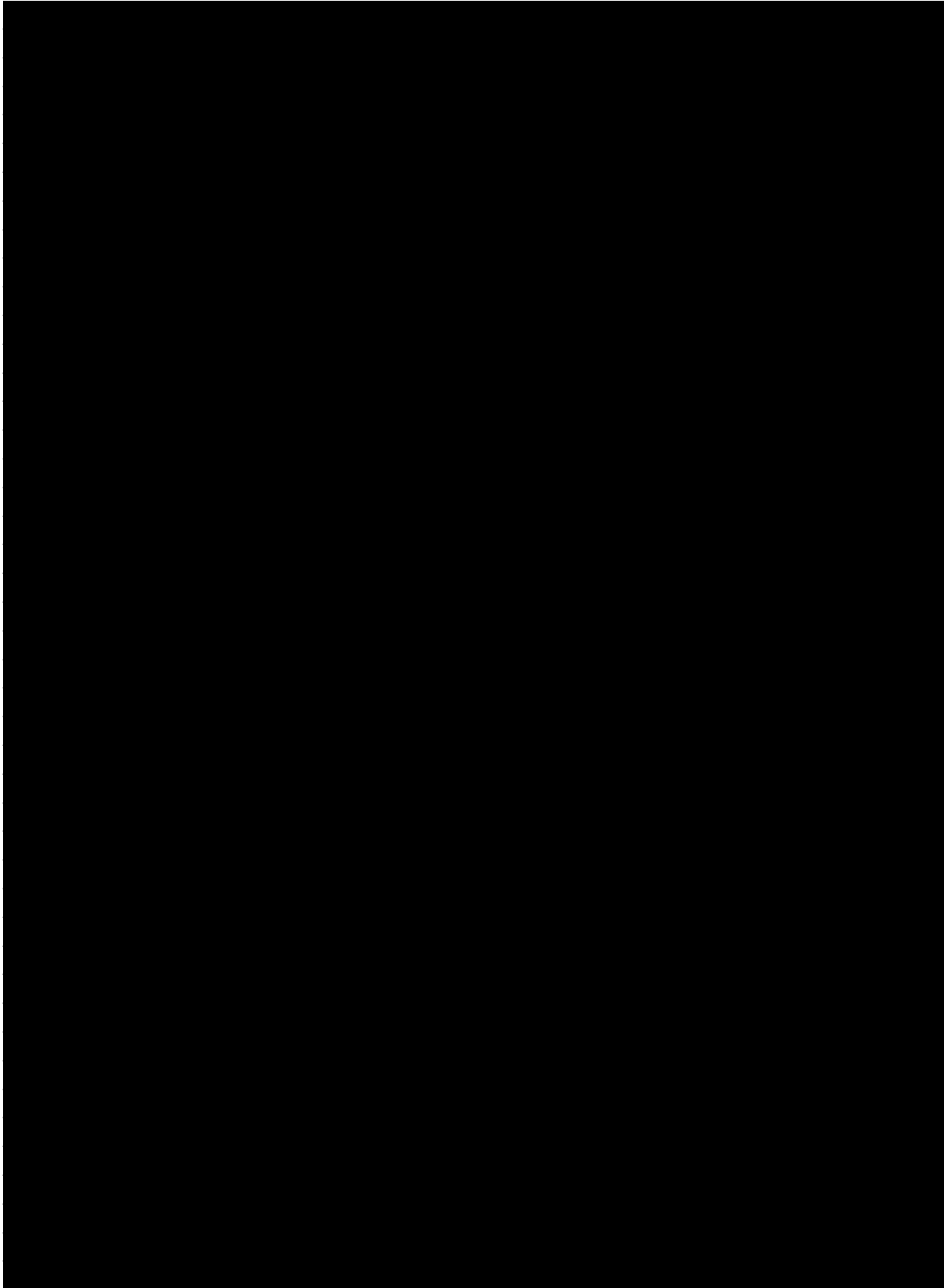








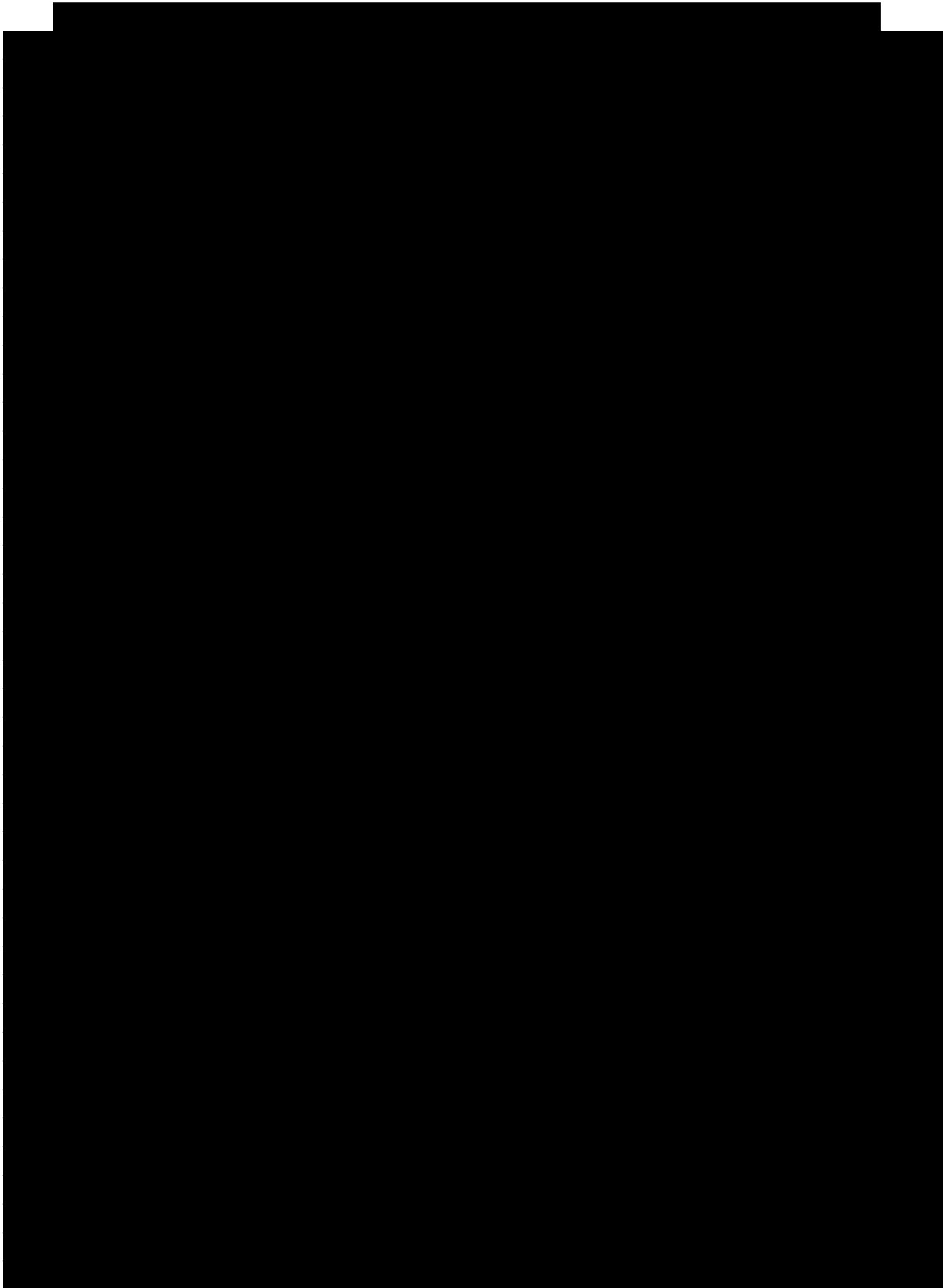


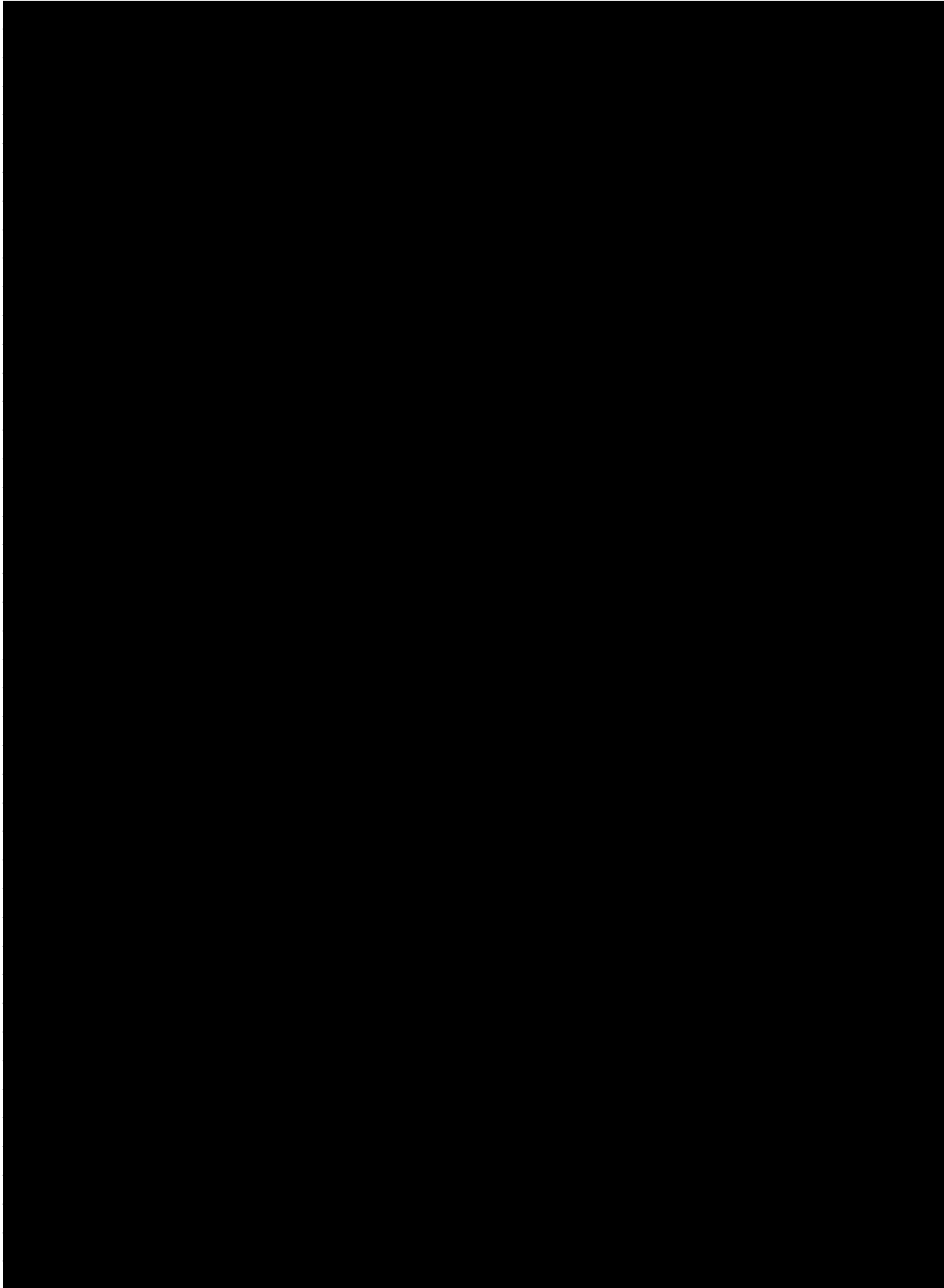


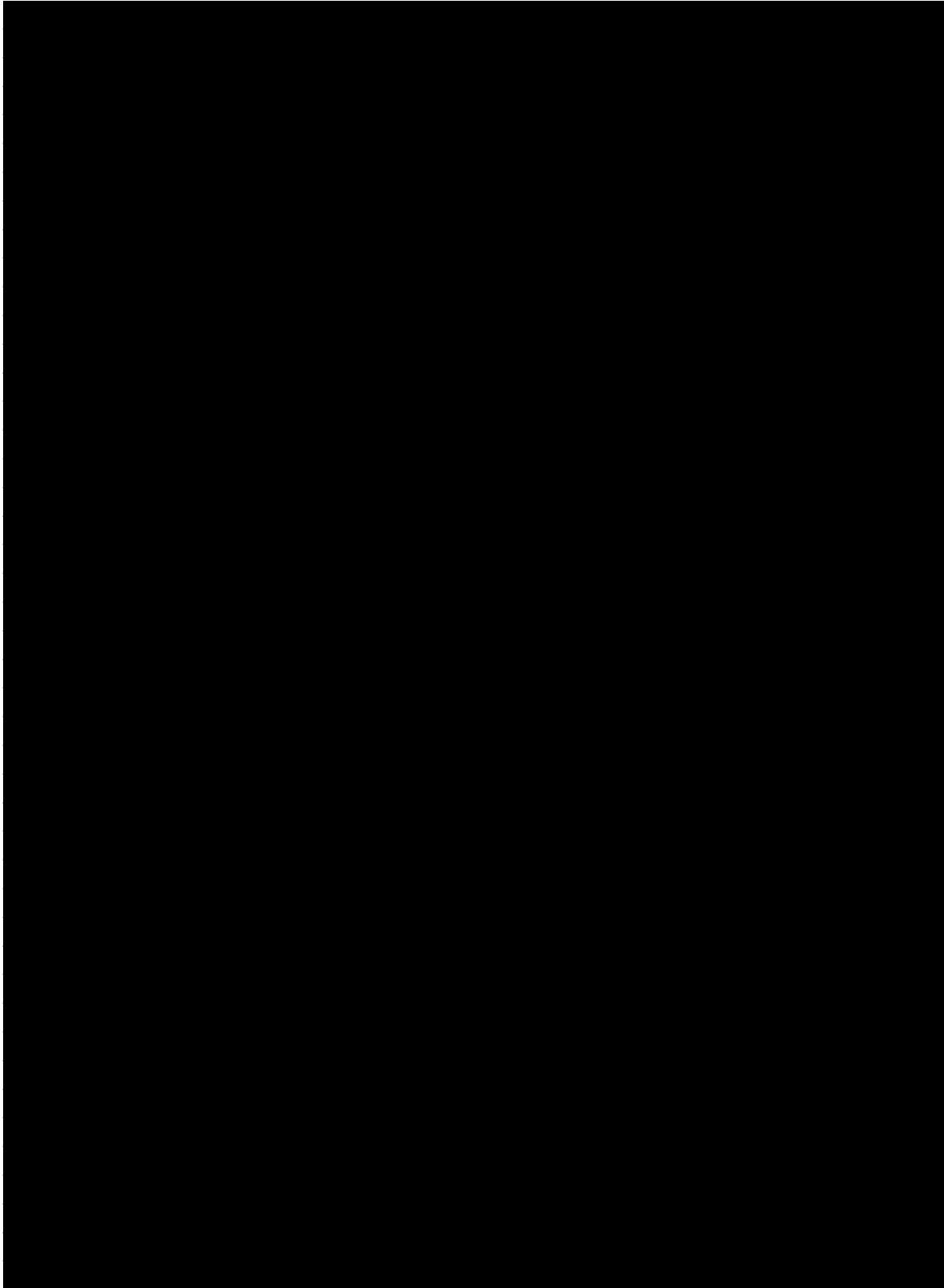


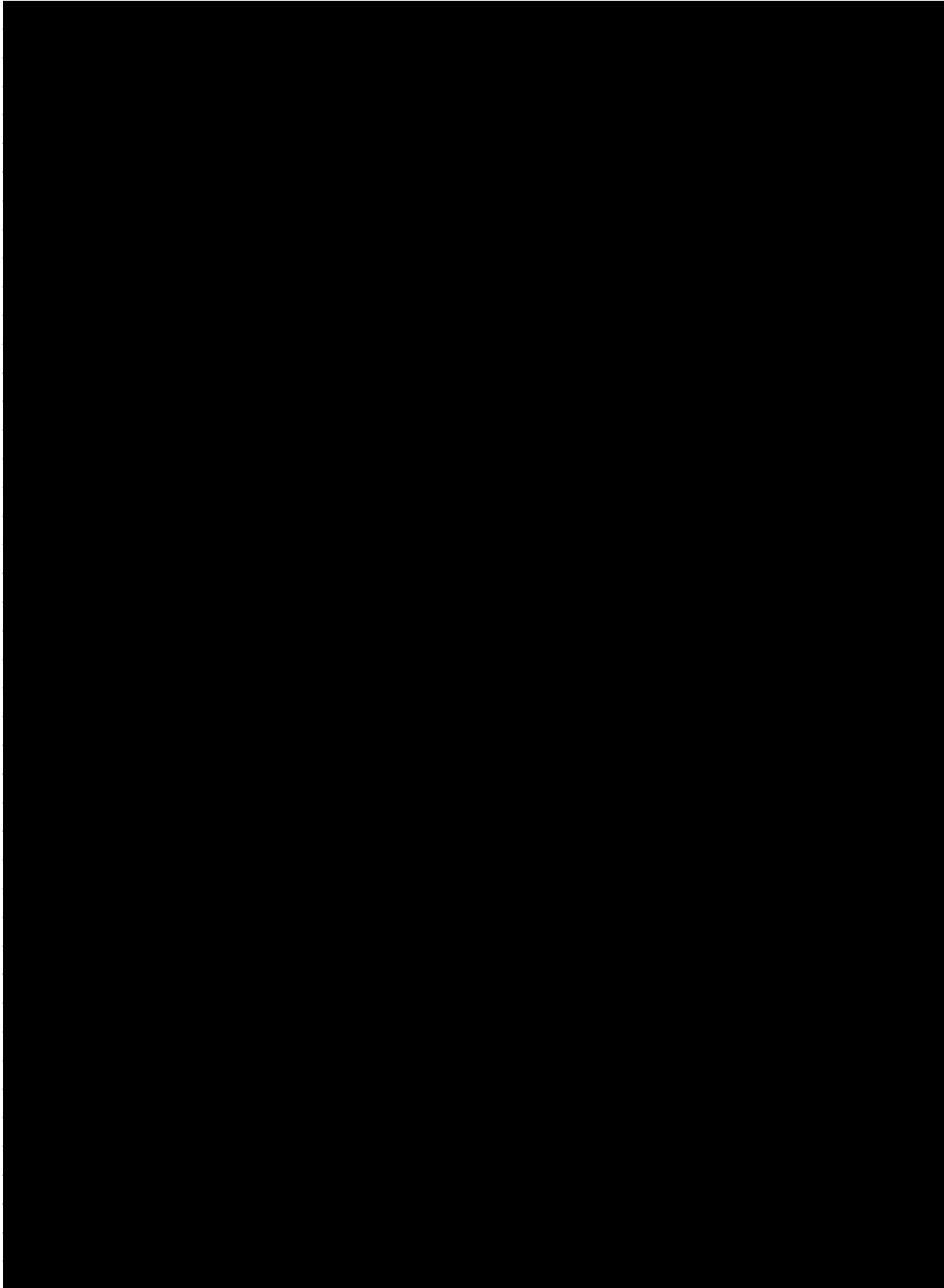
Social services districts should authorize assistance with recognized, medically necessary personal care services tasks. As previously advised, social services districts are **NOT** required to allot time for safety monitoring as a separate task as part of the total personal care services hours authorized (see GIS 99 MA/013, GIS 99 MA/036). However, districts are reminded that a clear and legitimate distinction exists between “safety monitoring” as a non-required independent stand-alone function while no Level II personal care services task is being provided, and the appropriate monitoring of the patient while providing assistance with the performance of a Level II personal care services task, such as transferring, toileting, or walking, to assure the task is being safely completed.

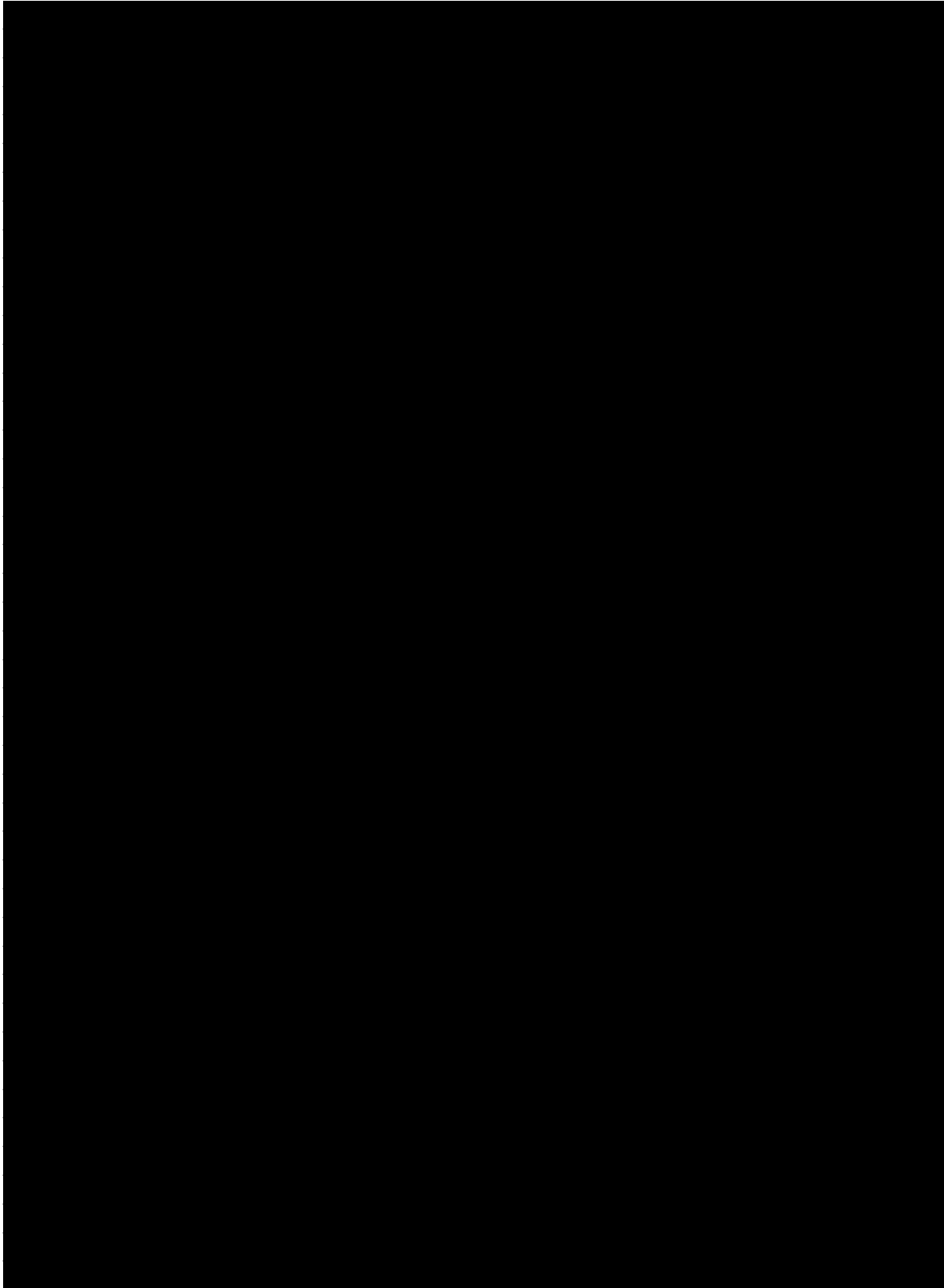
18 NYCRR 358-5.9(a) provides:

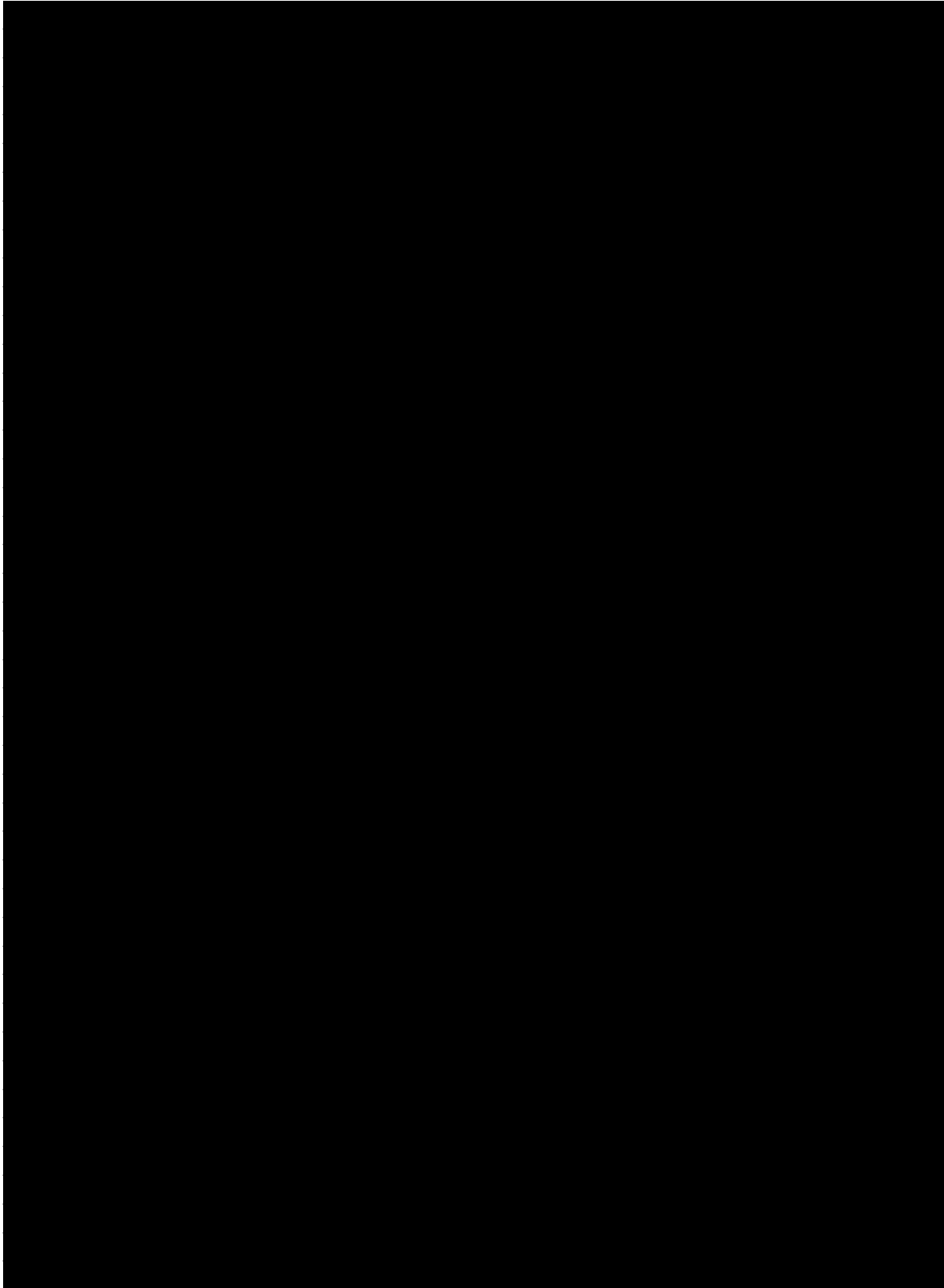


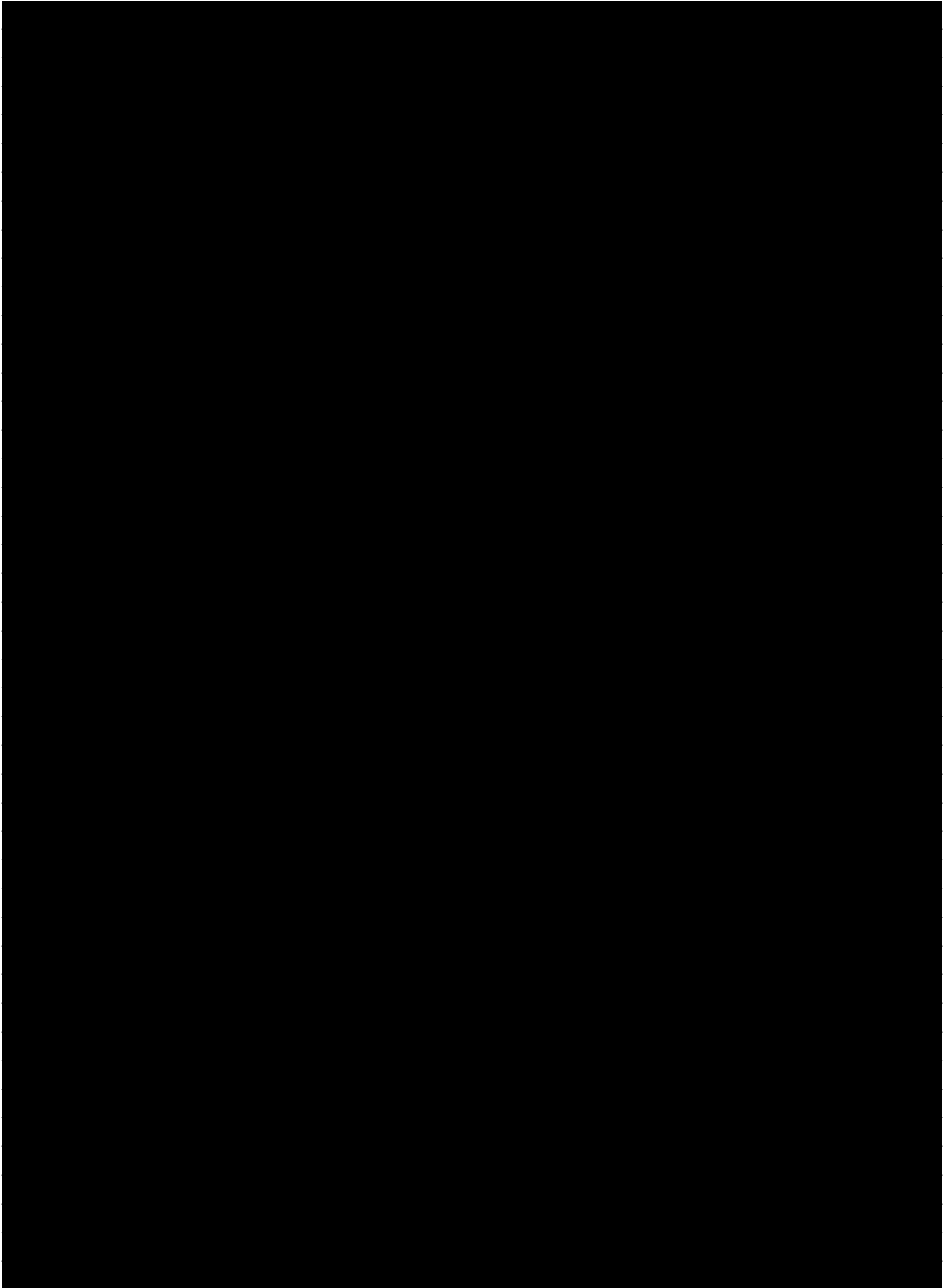








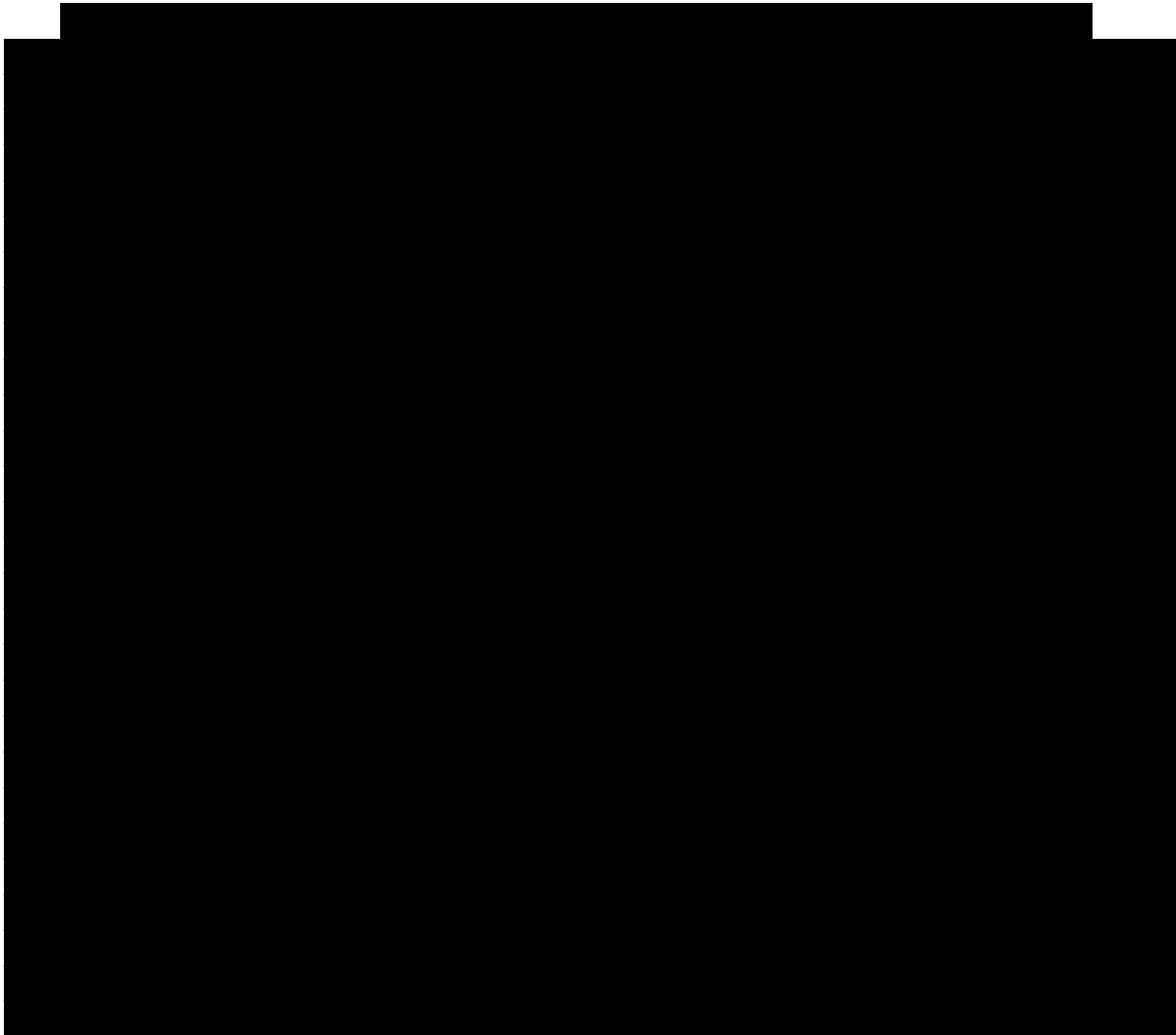


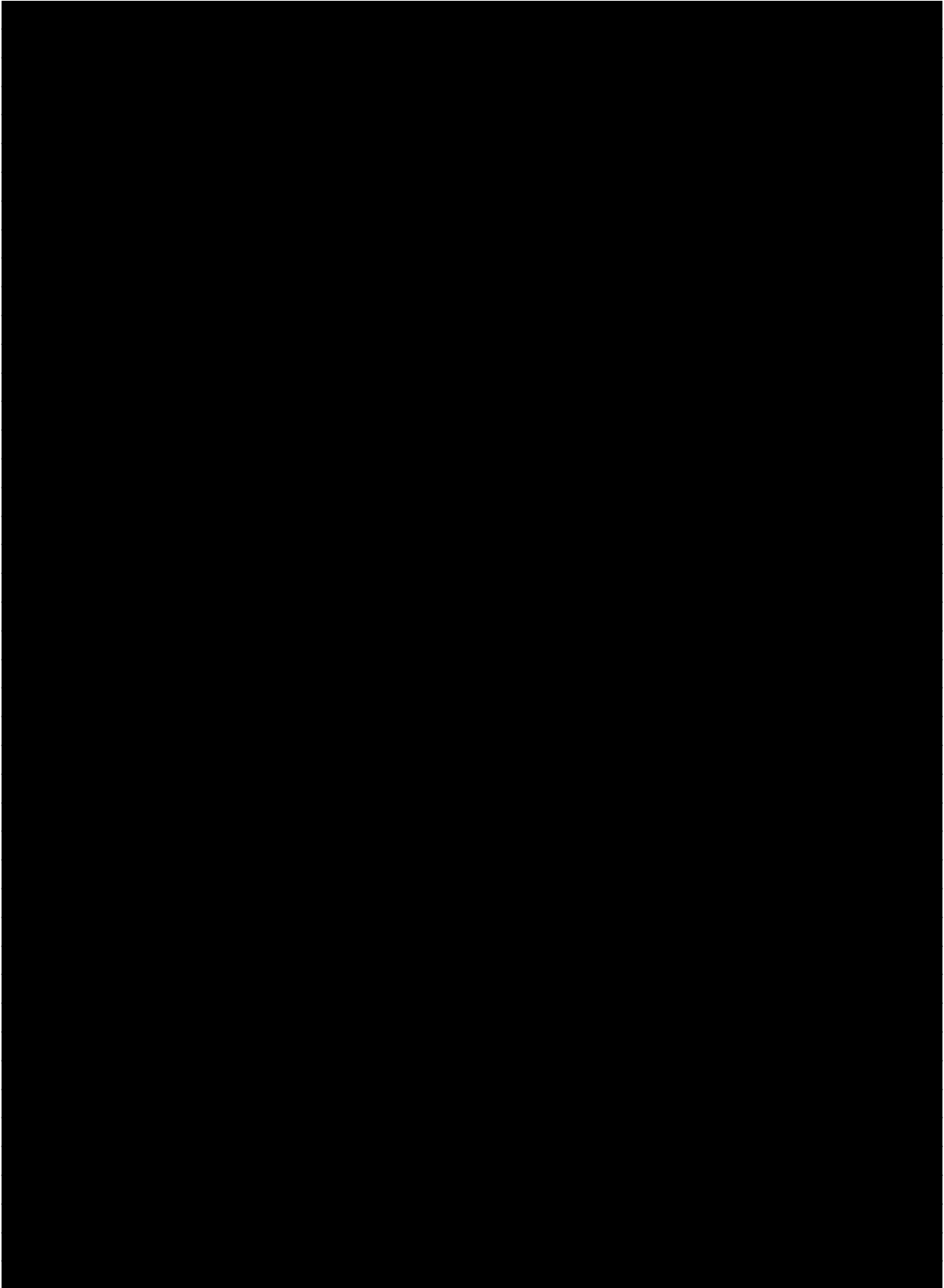


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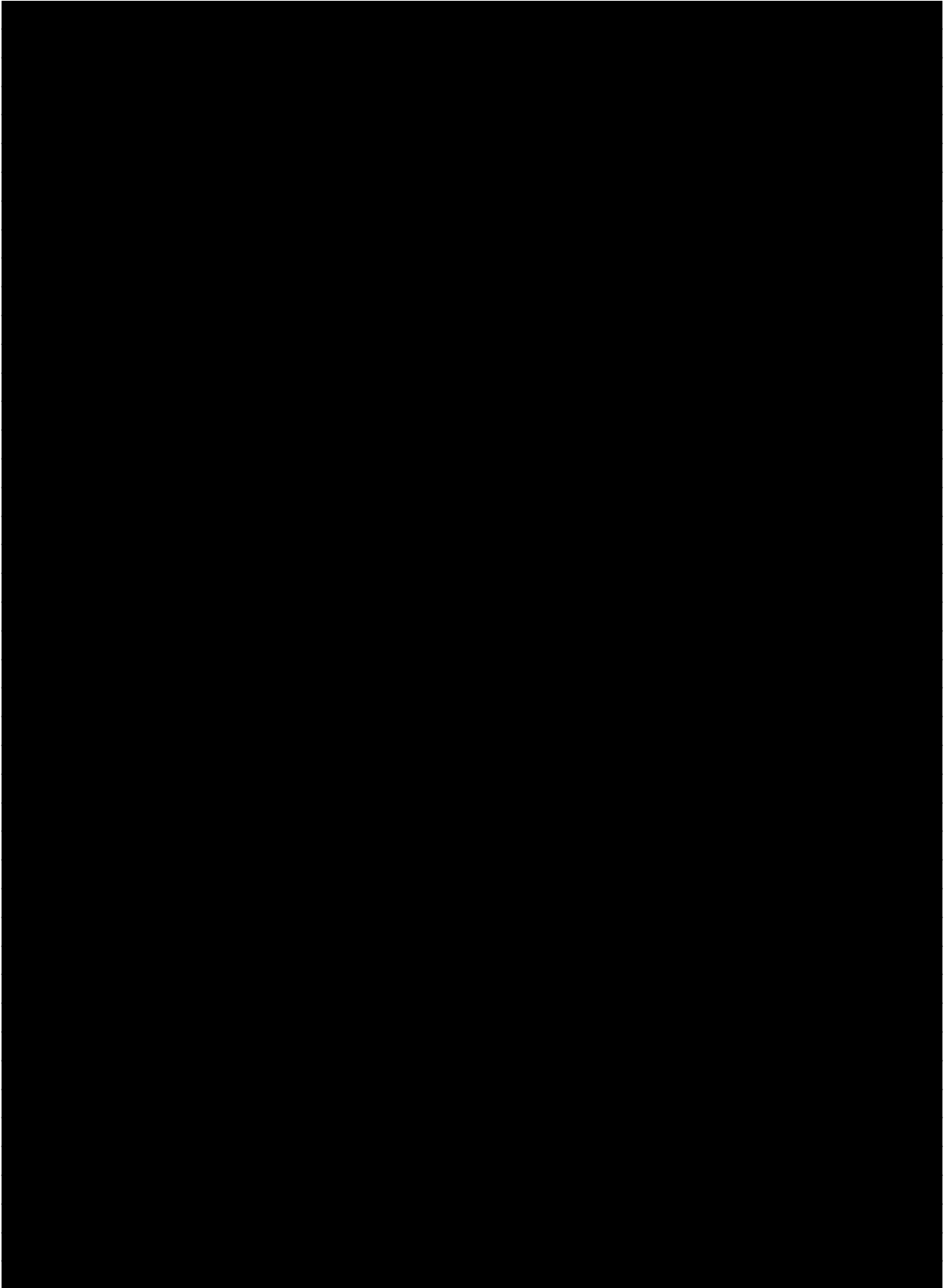


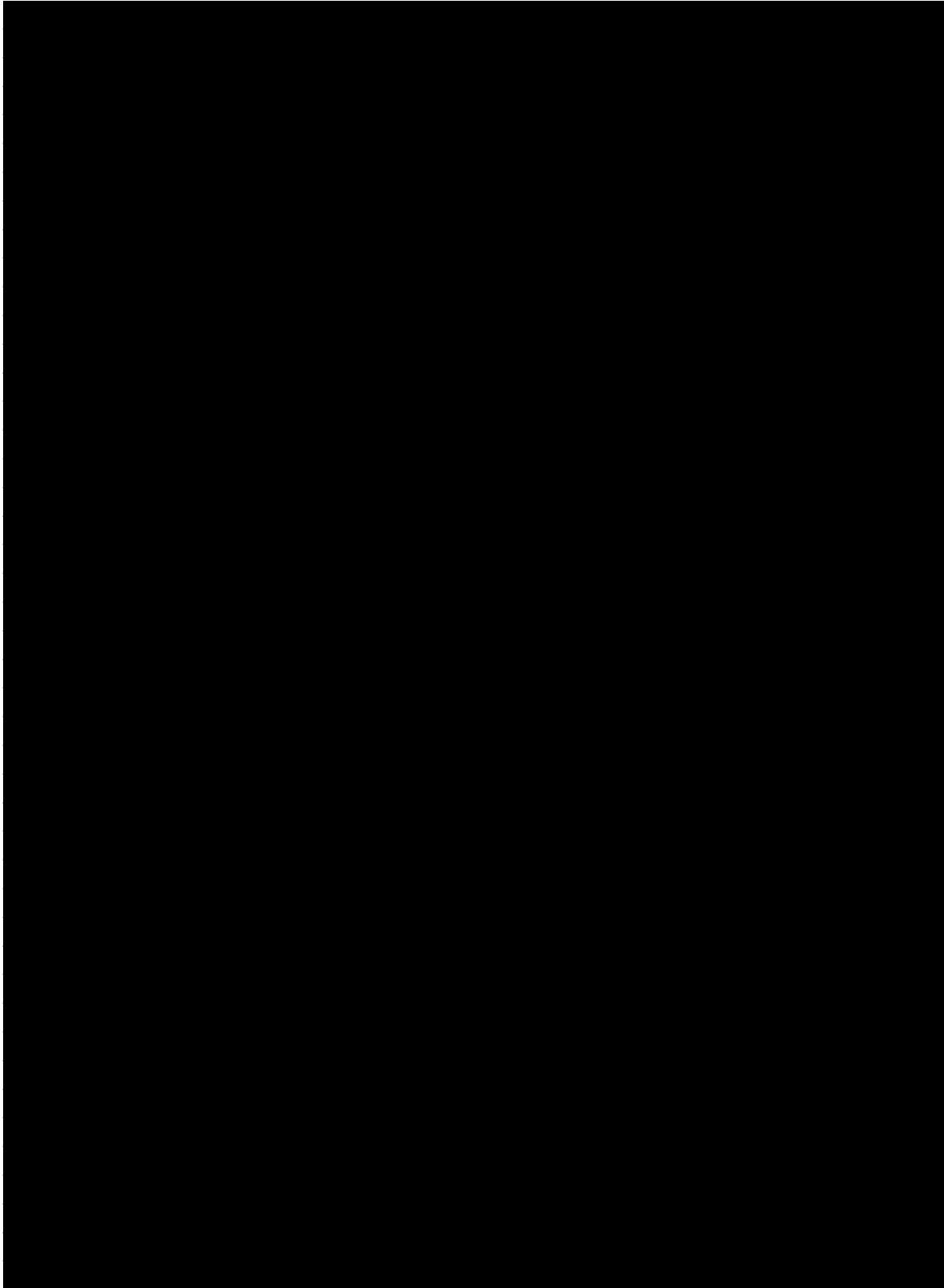
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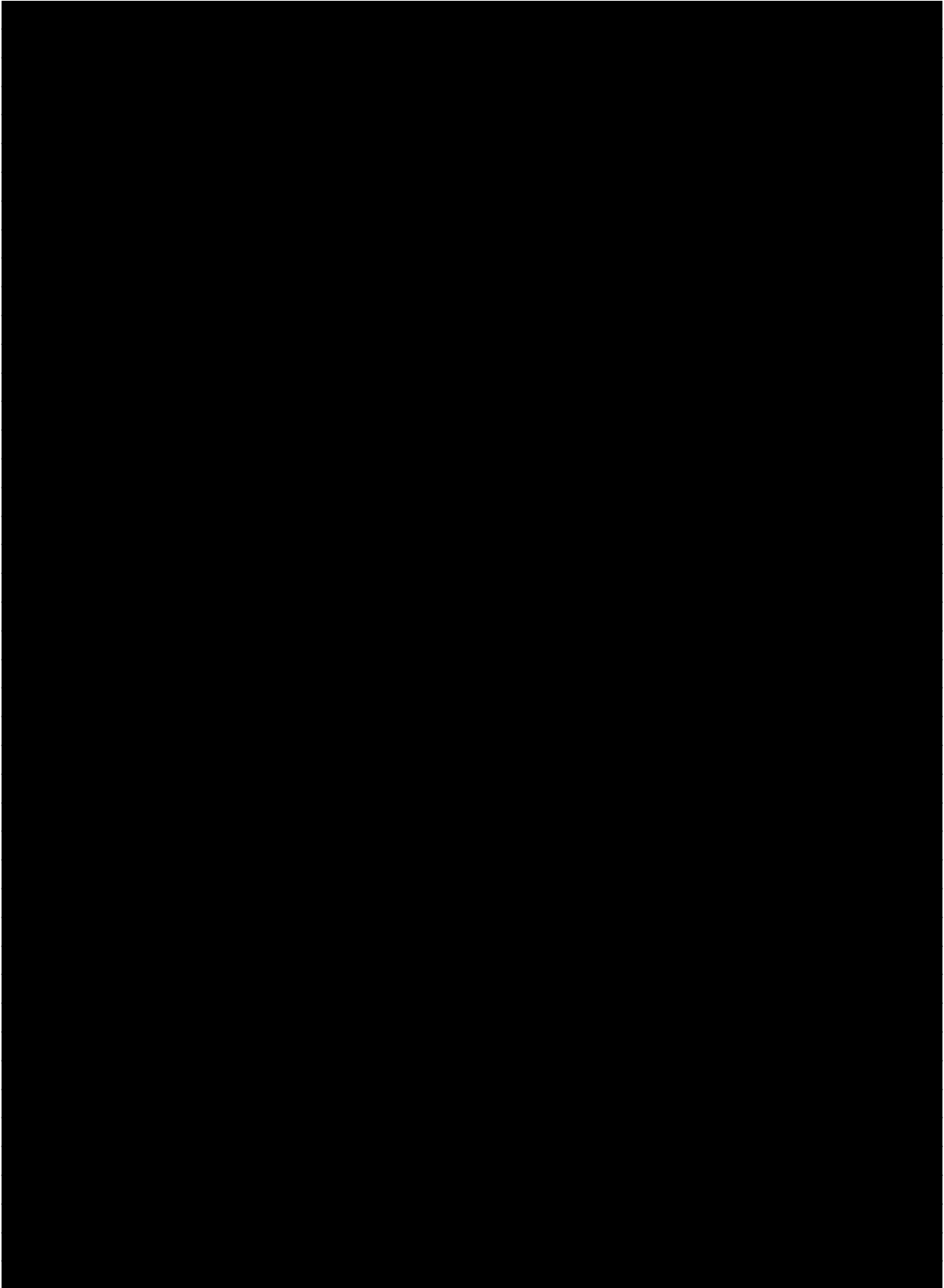


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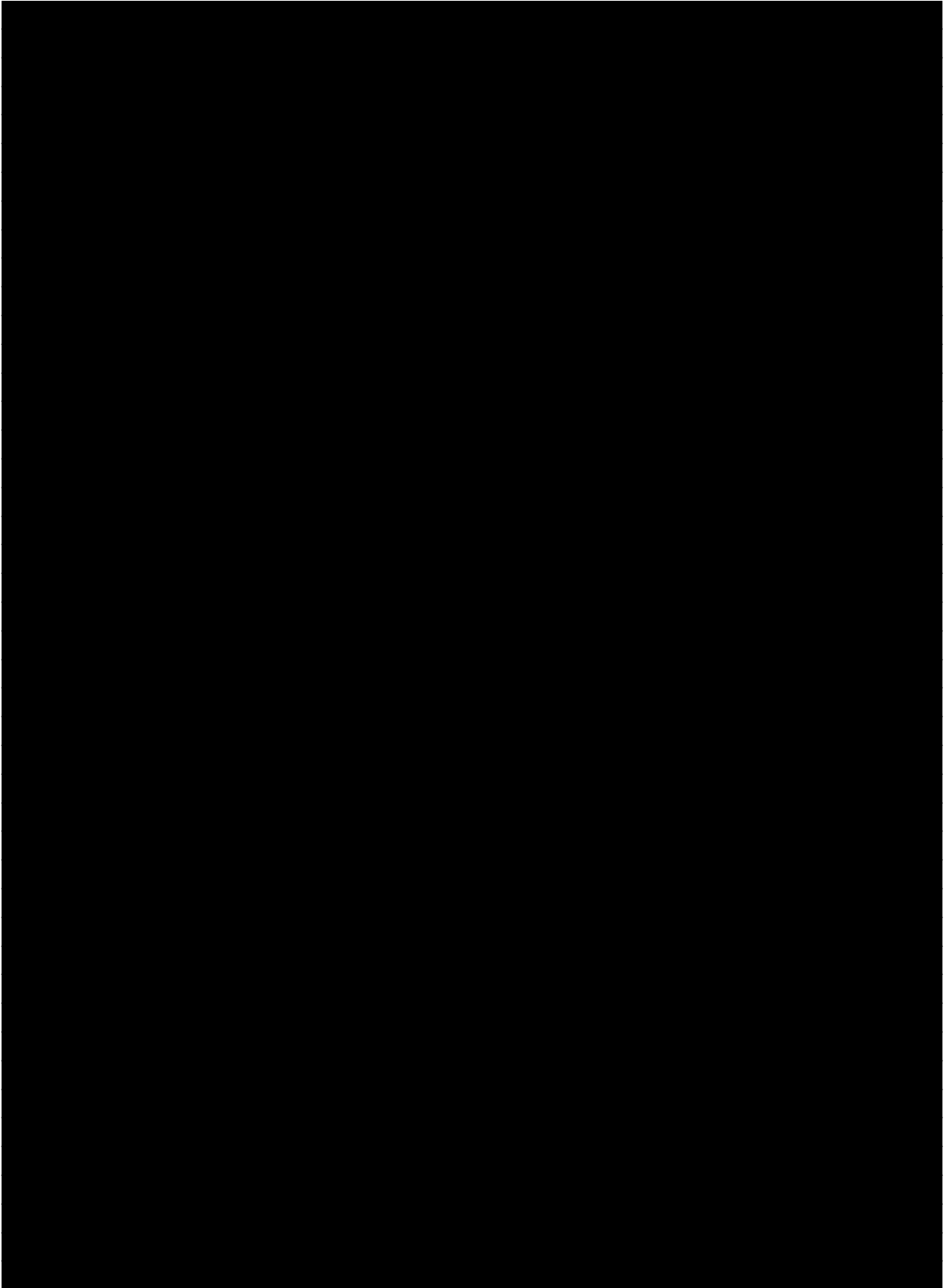




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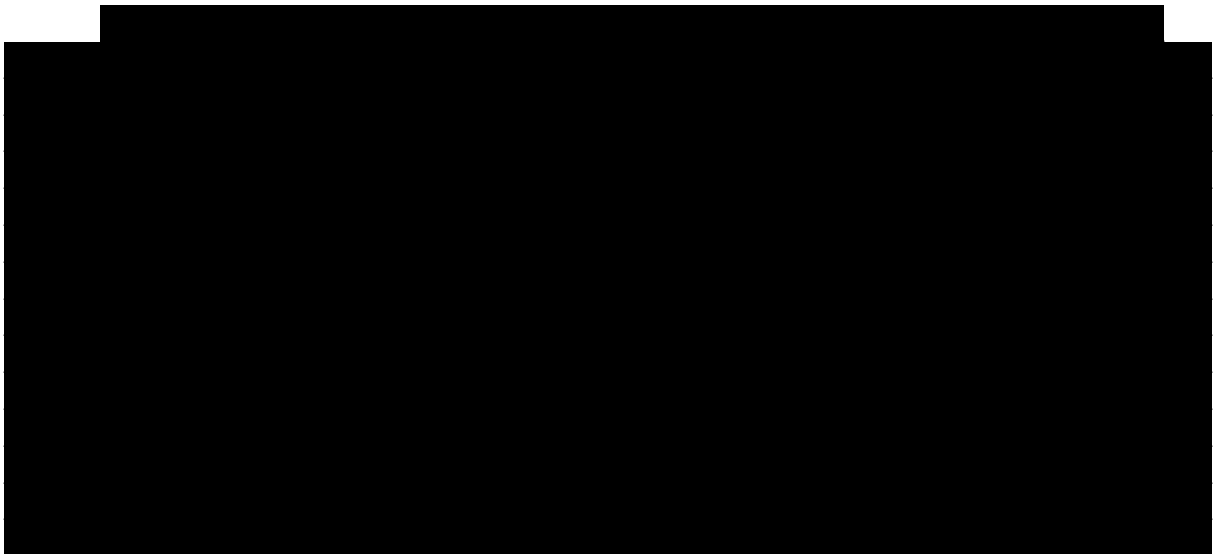
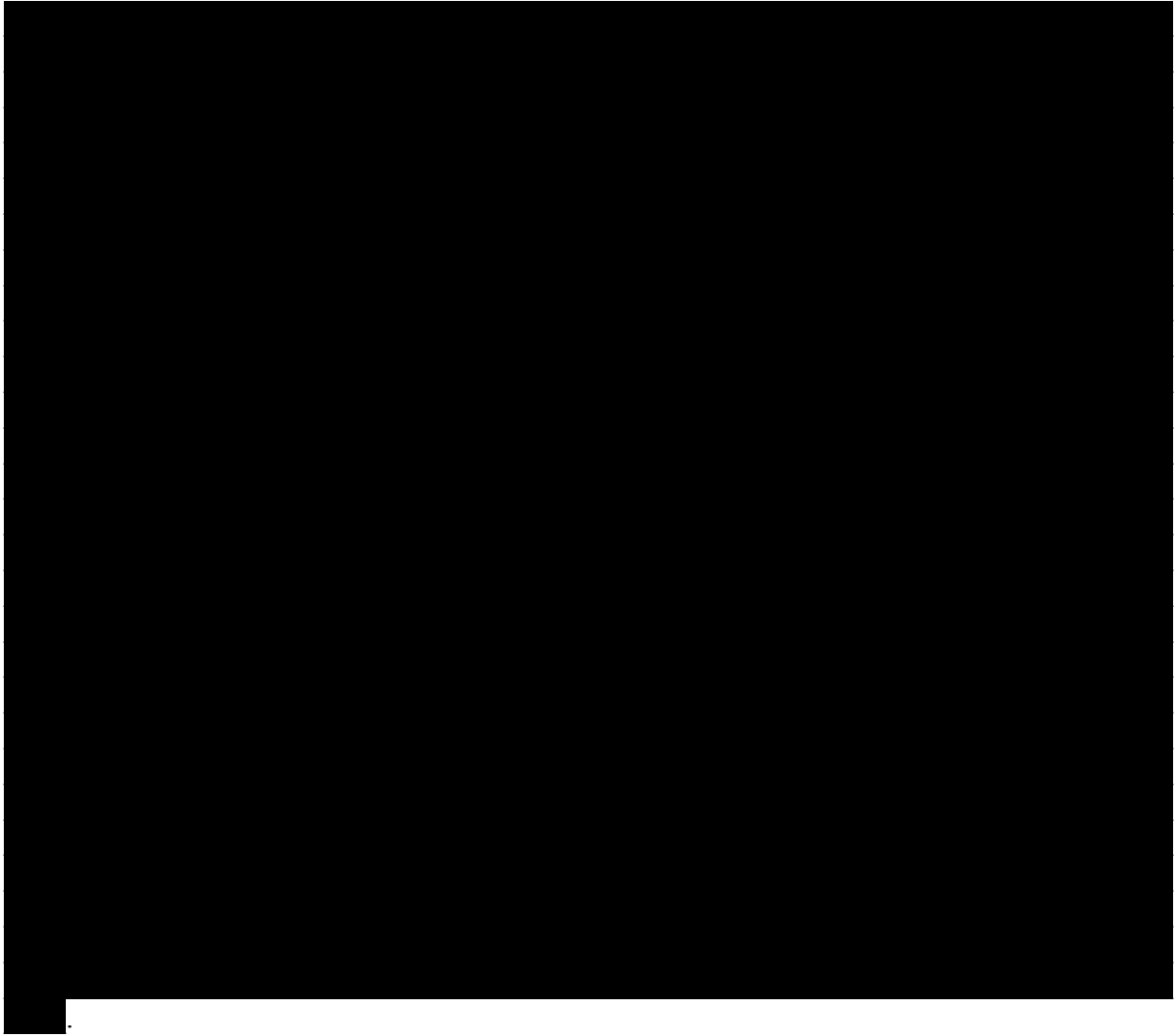


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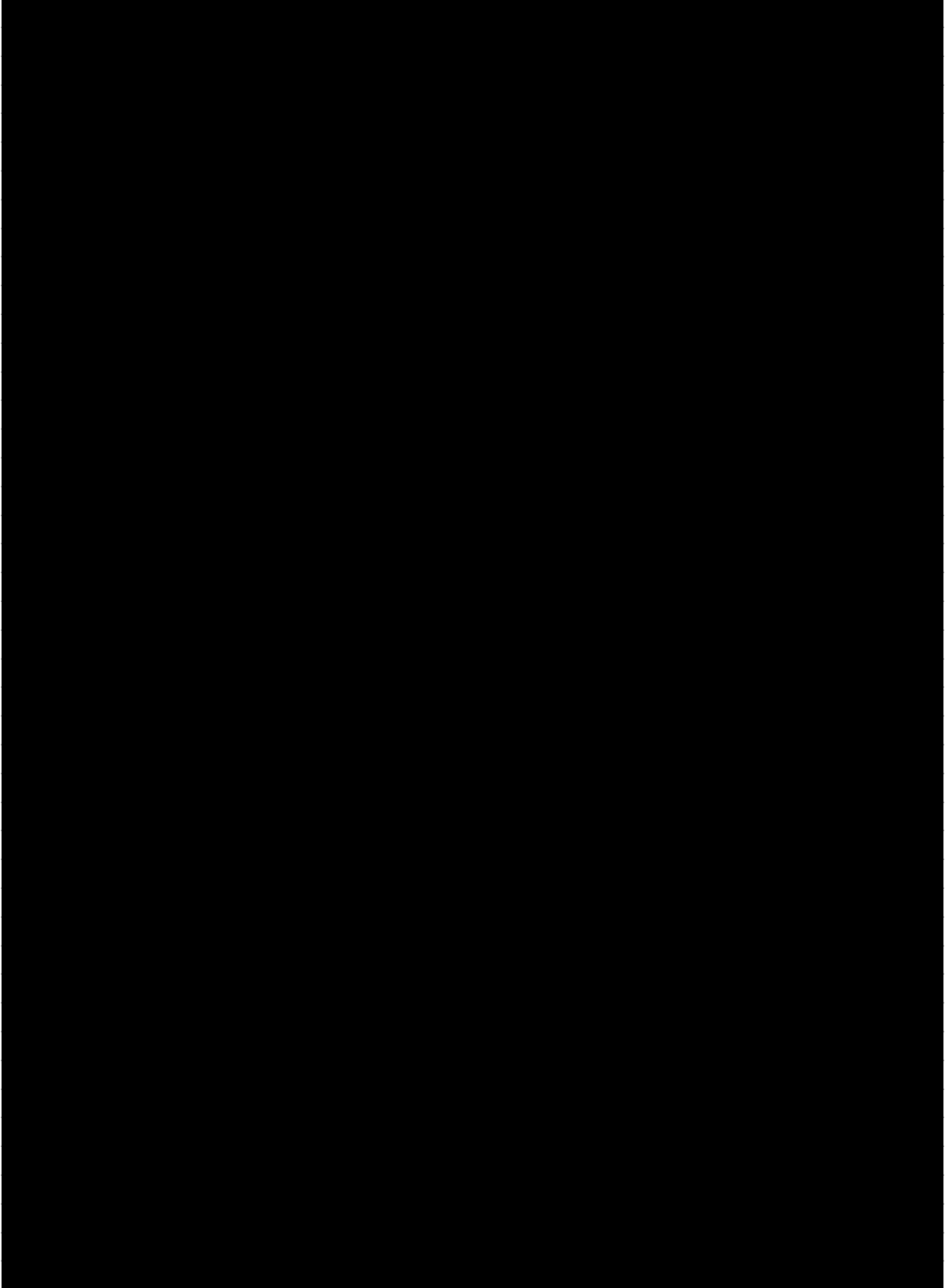


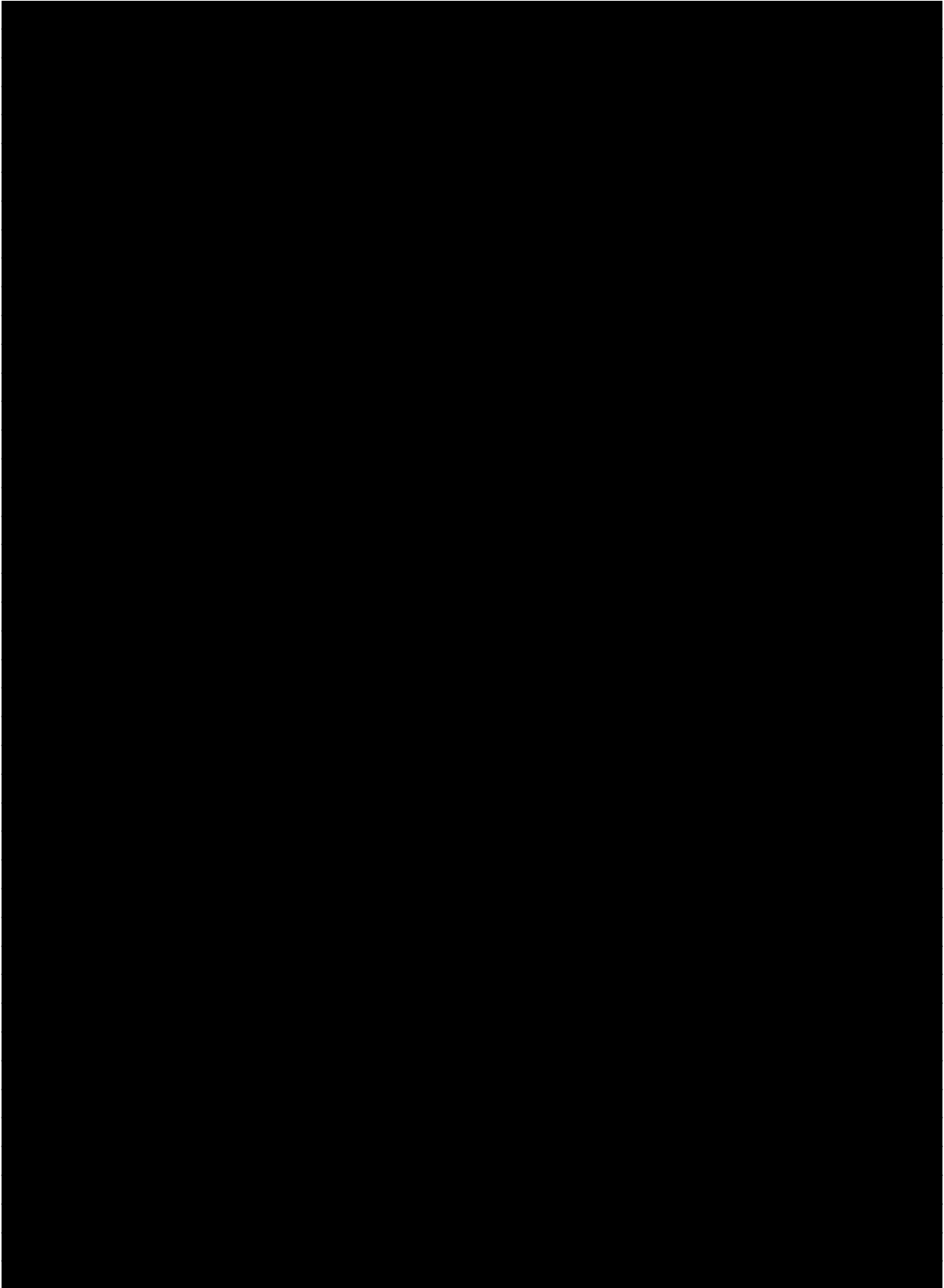


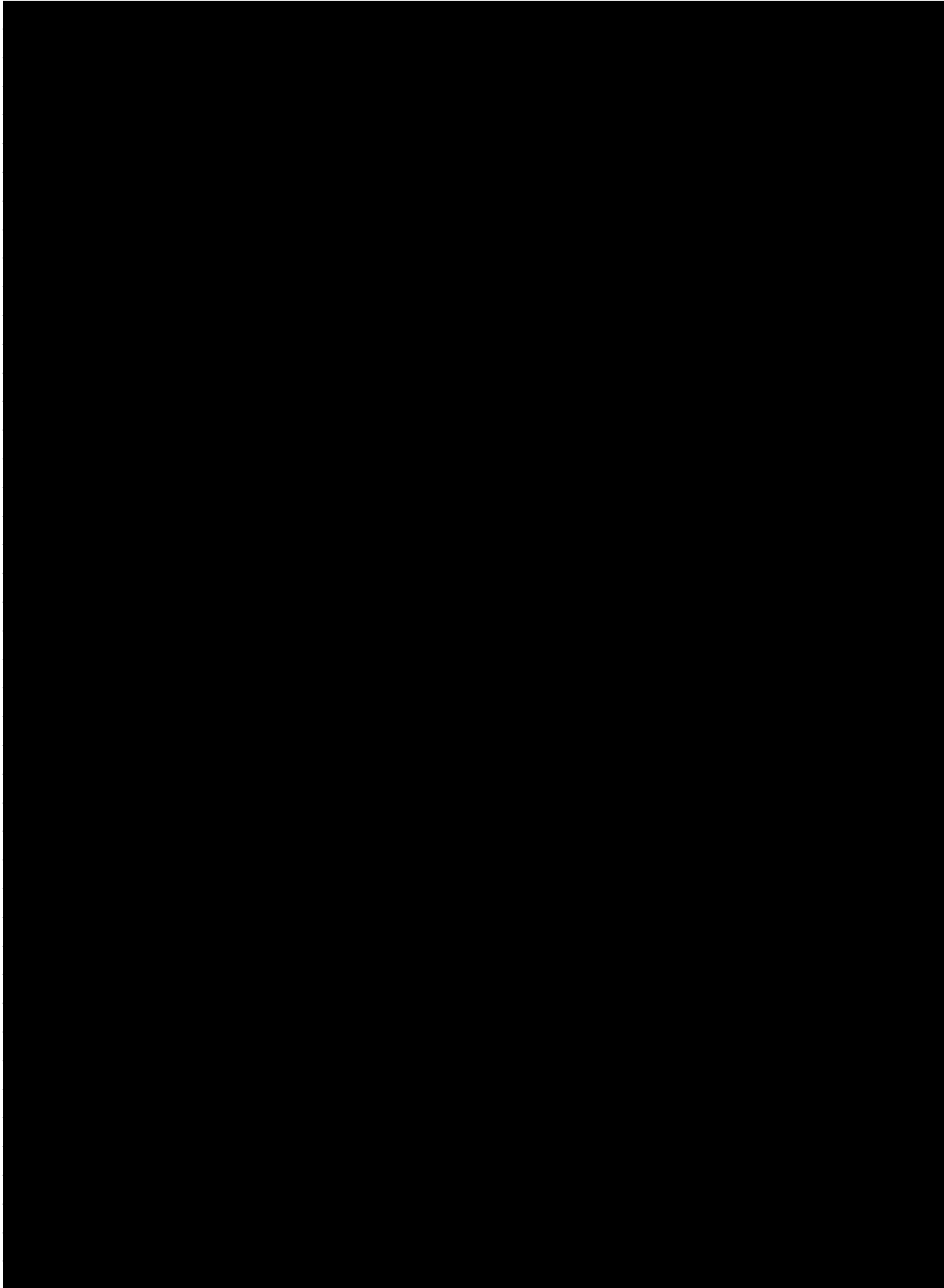
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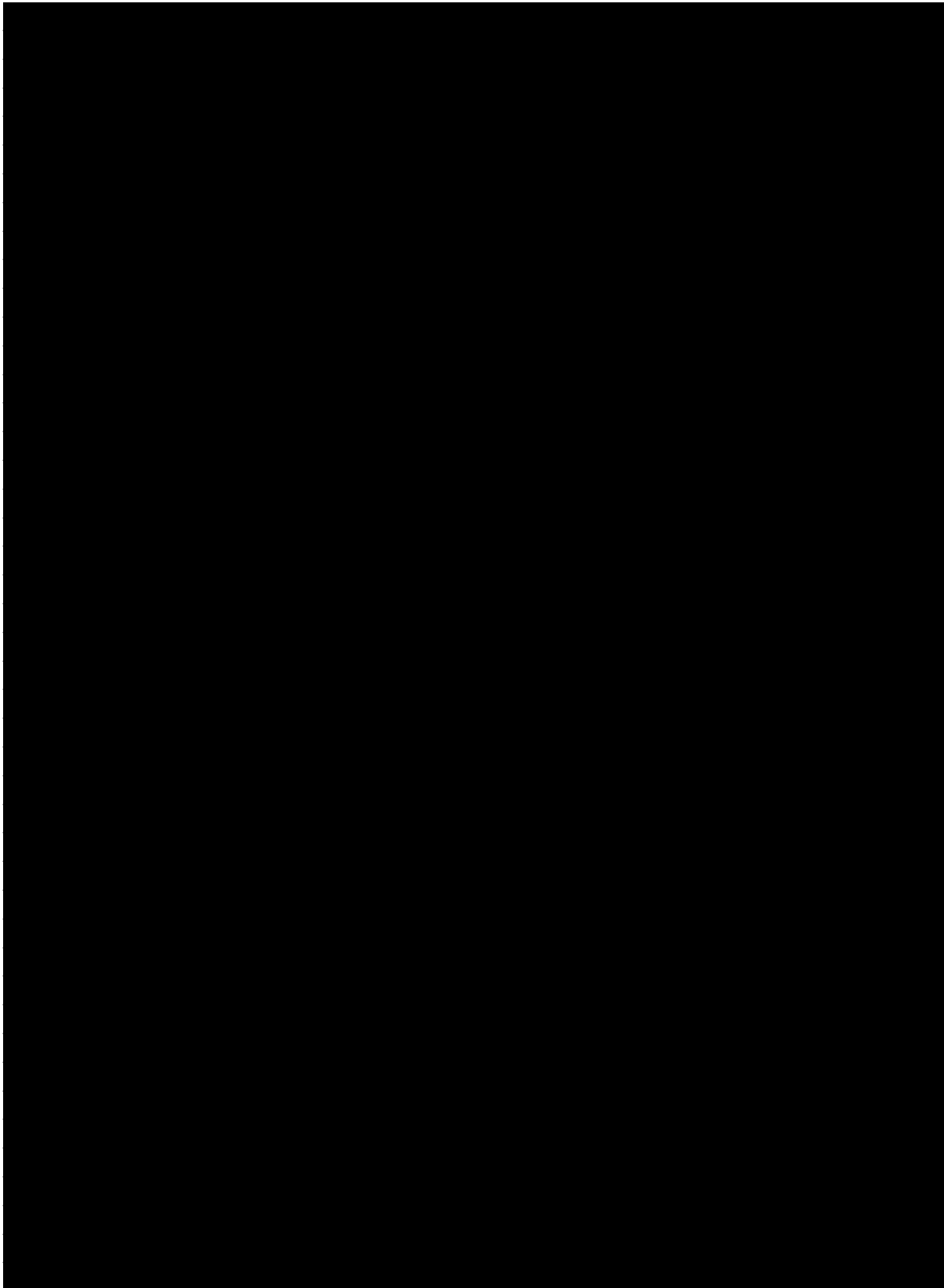


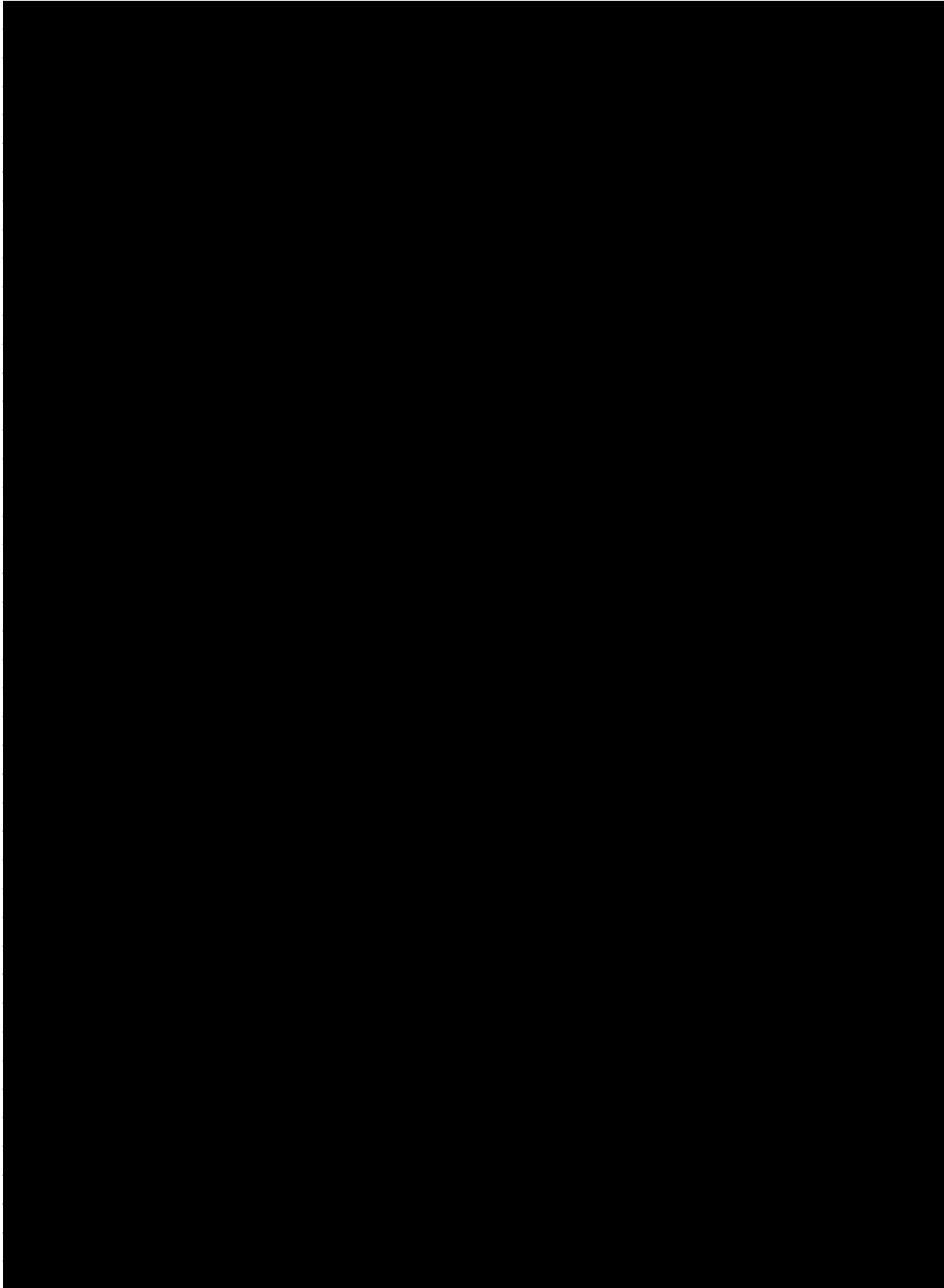
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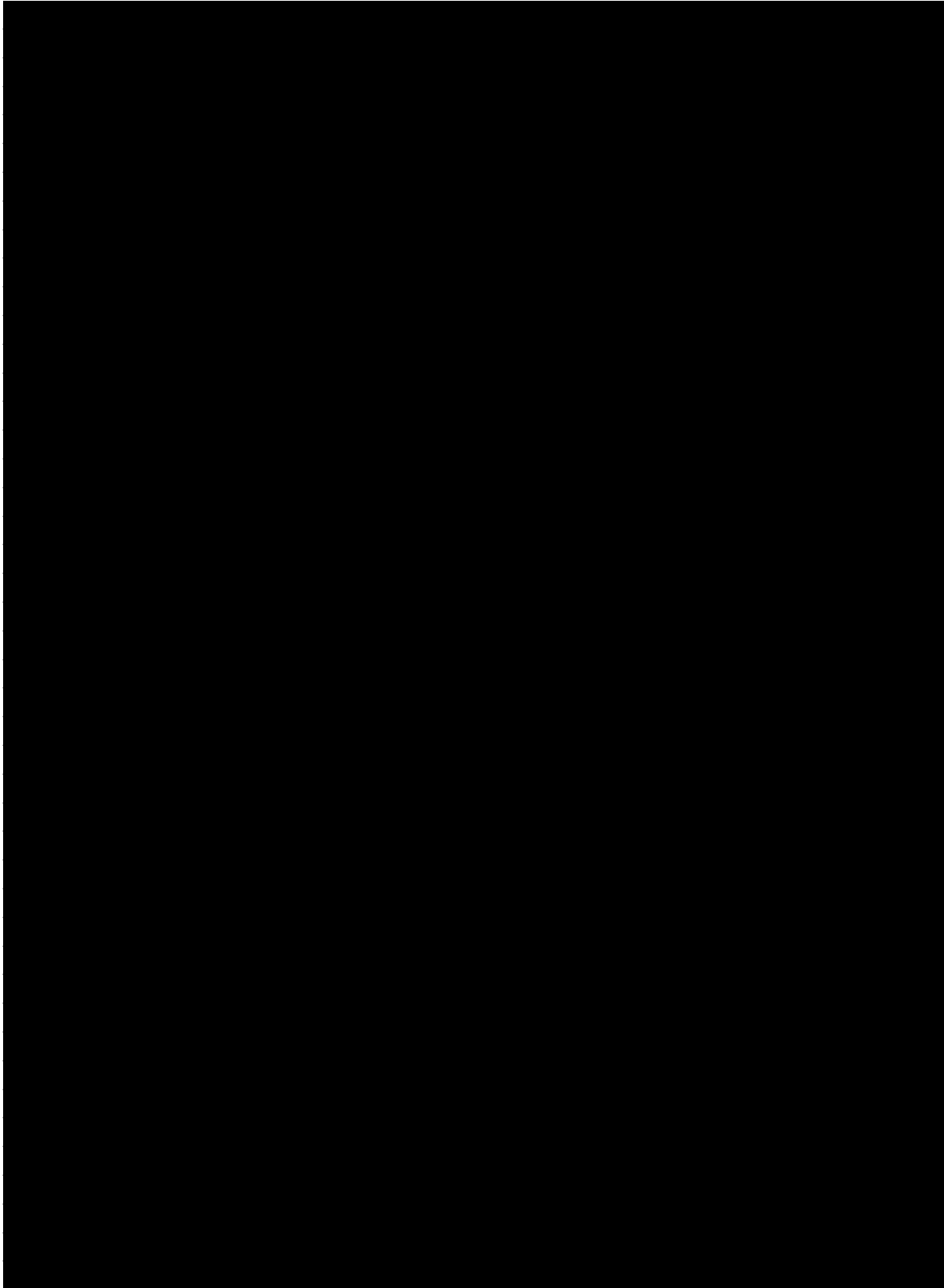




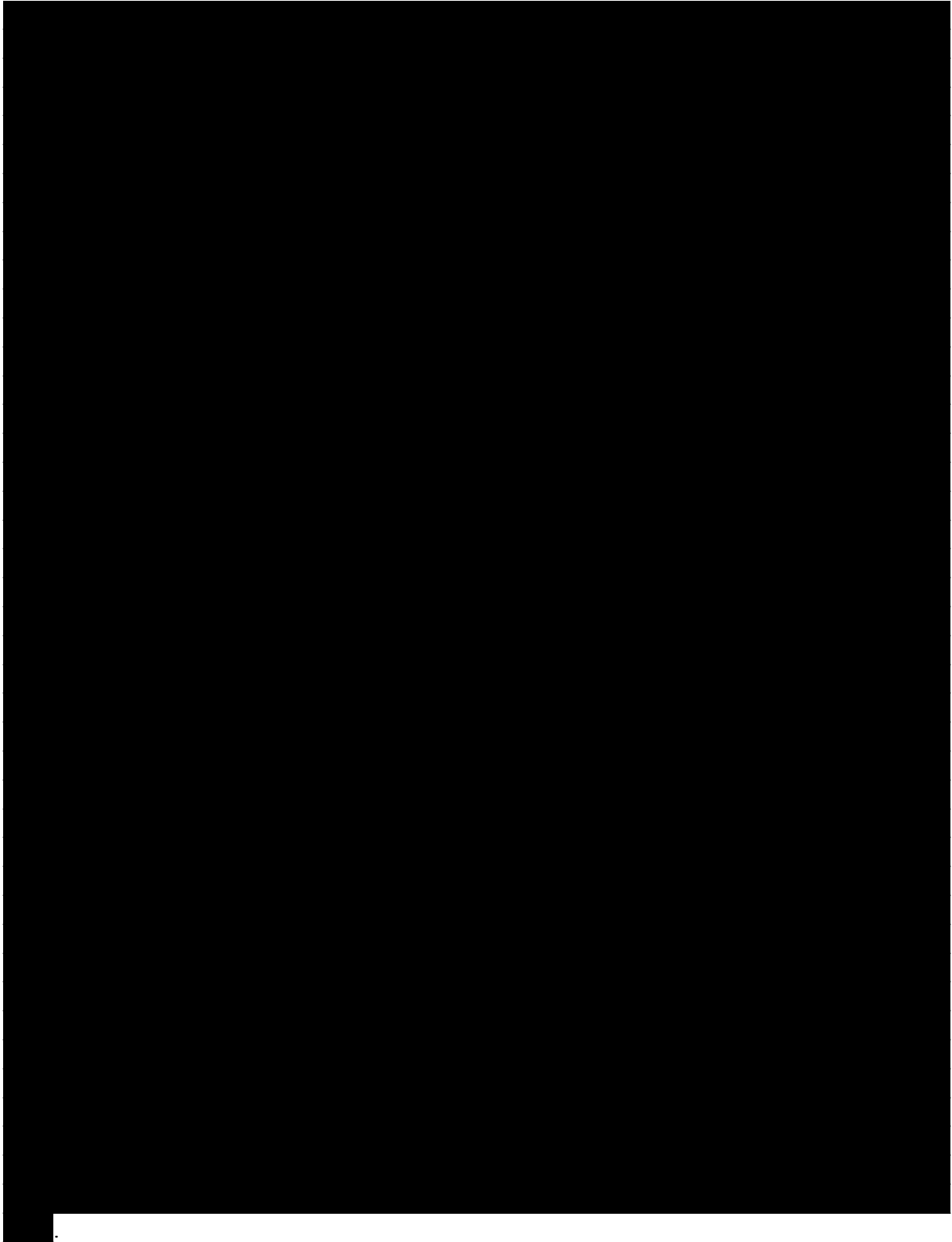




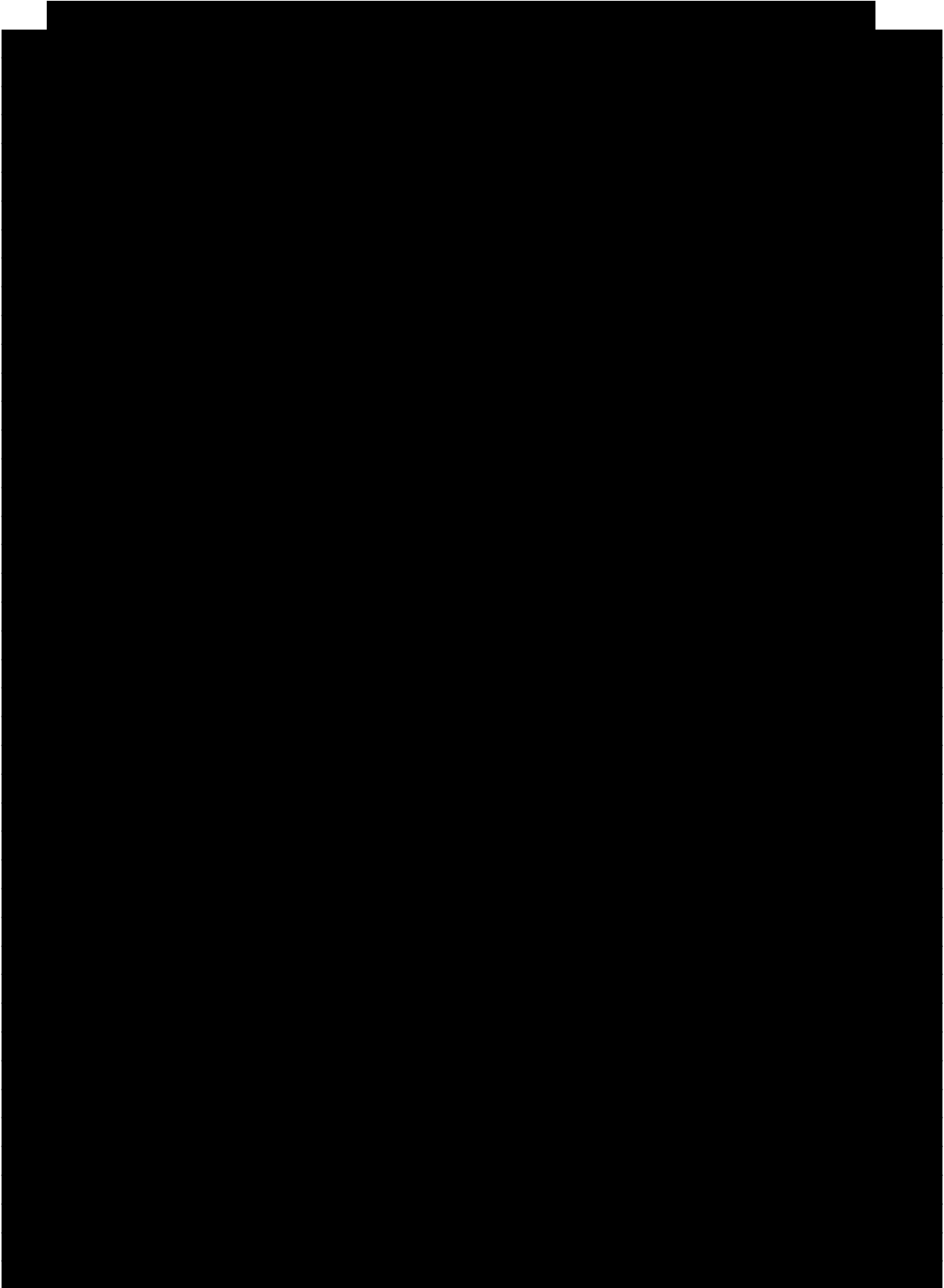


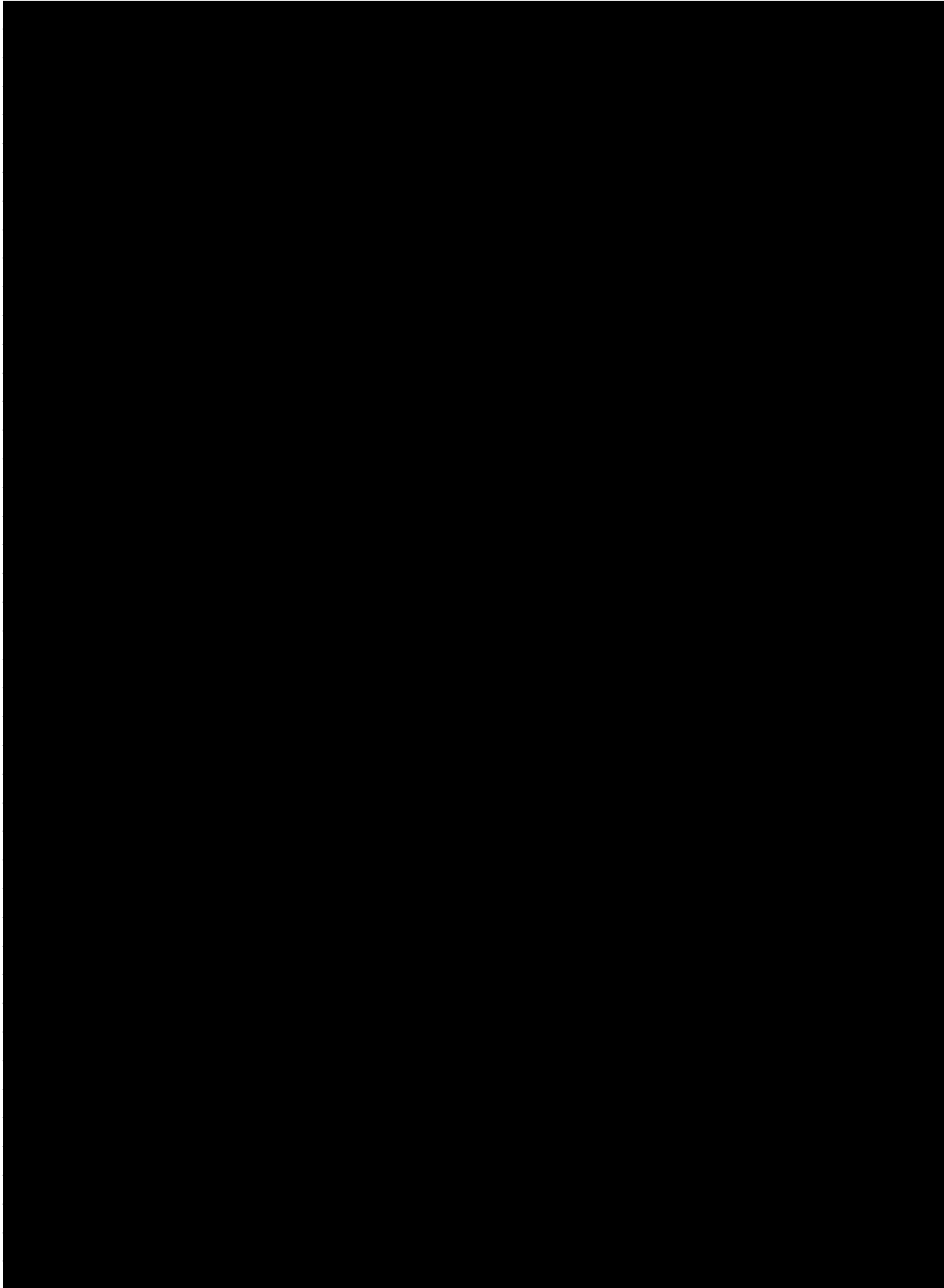


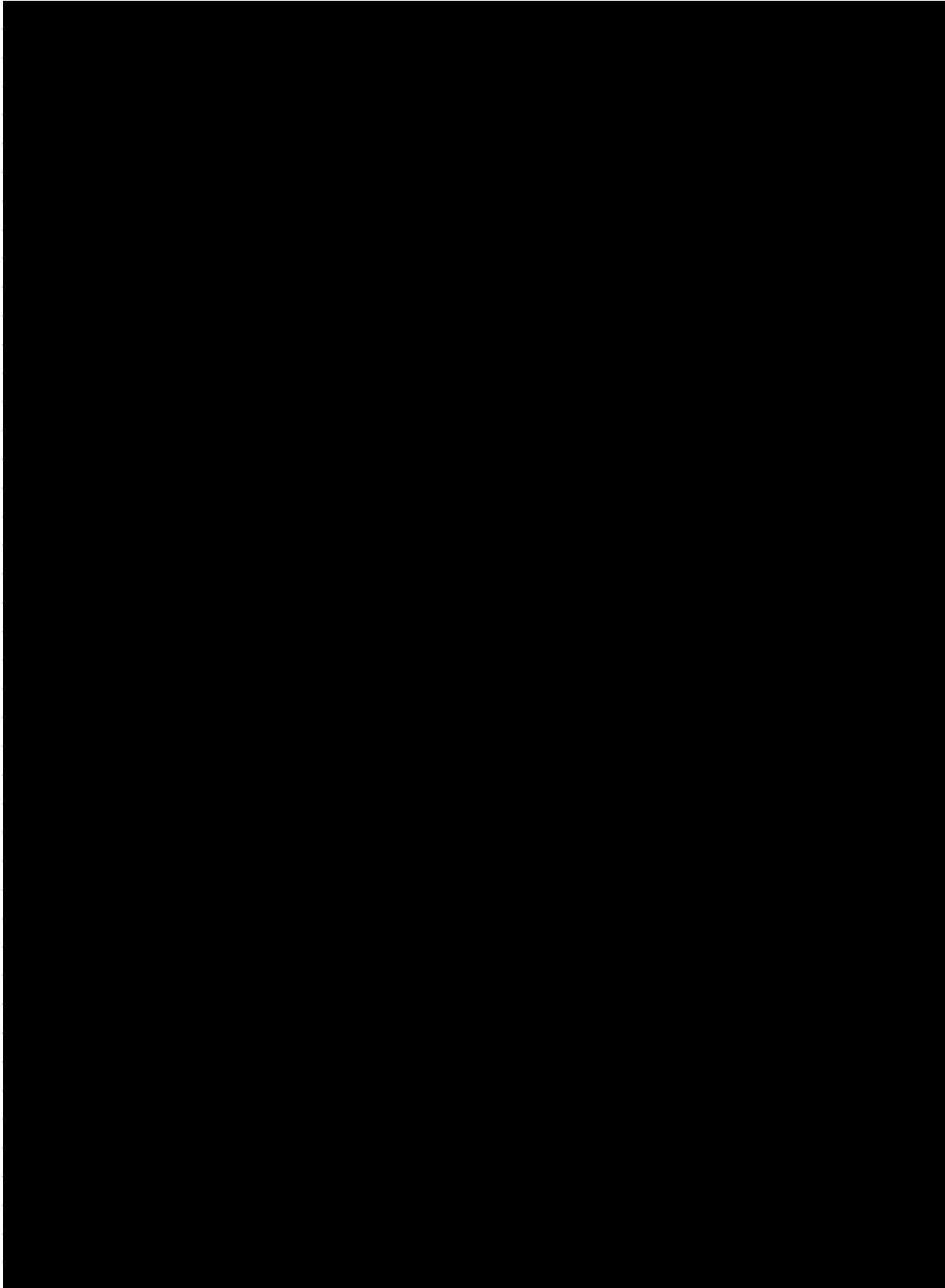
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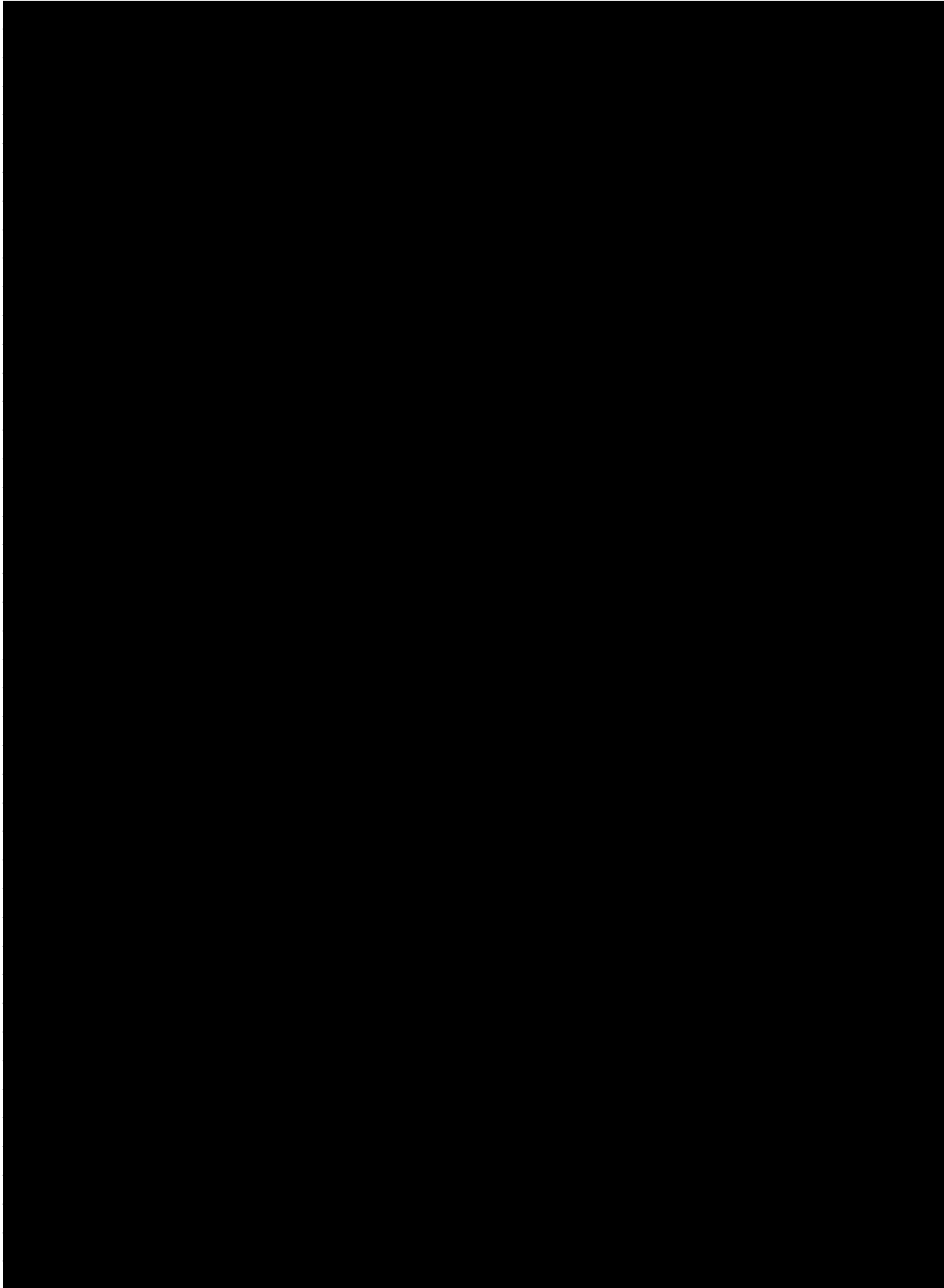


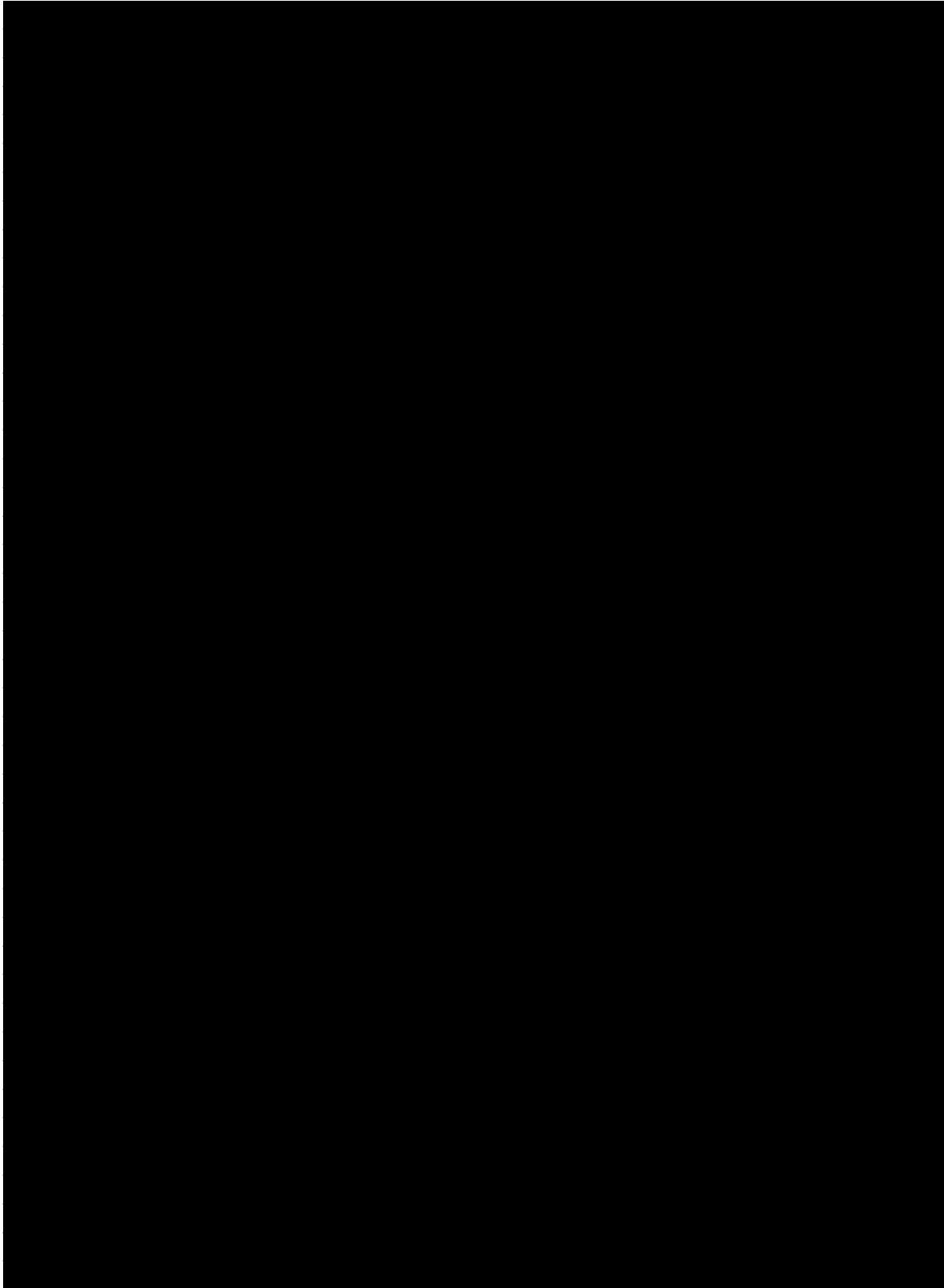
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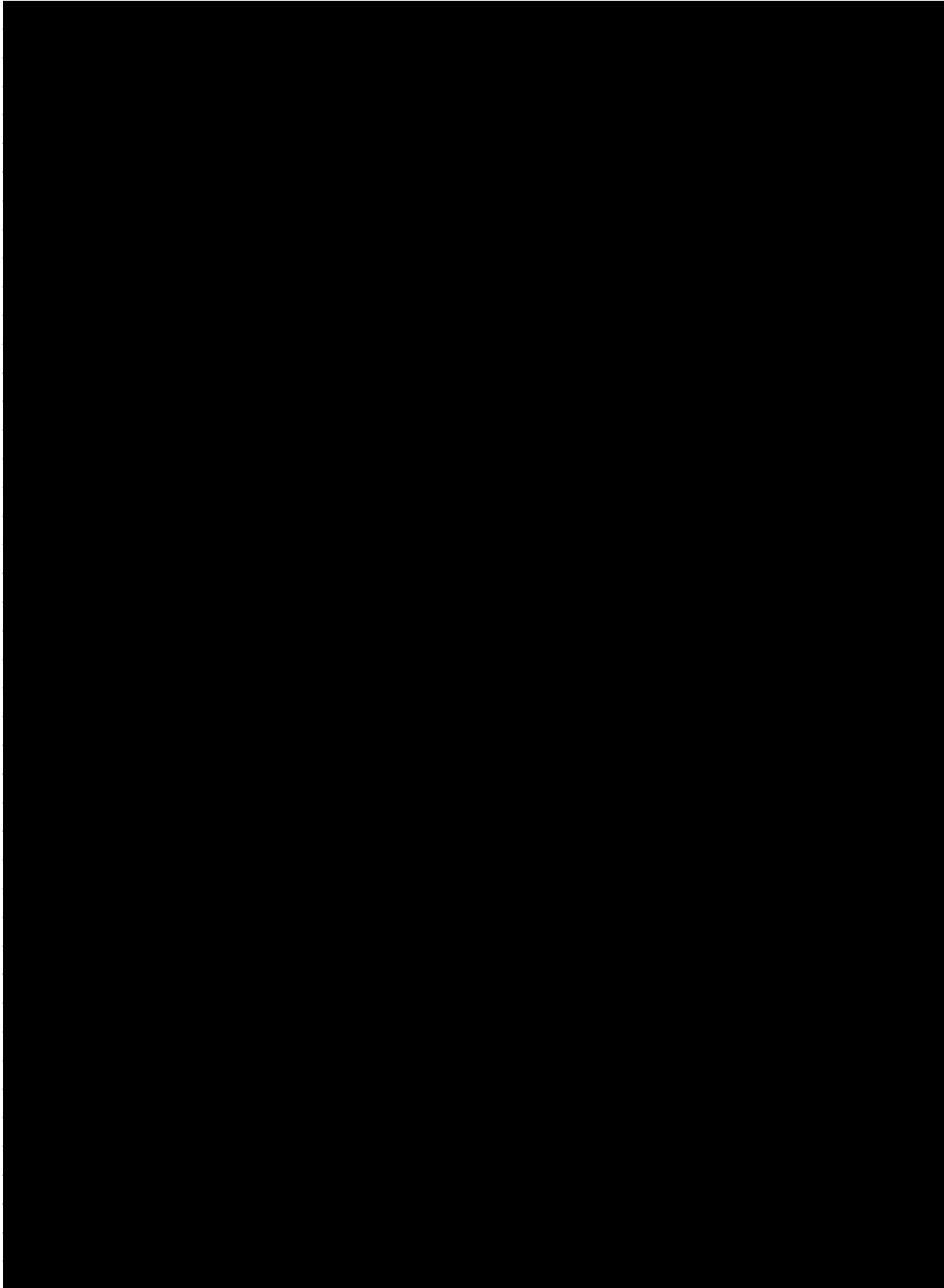


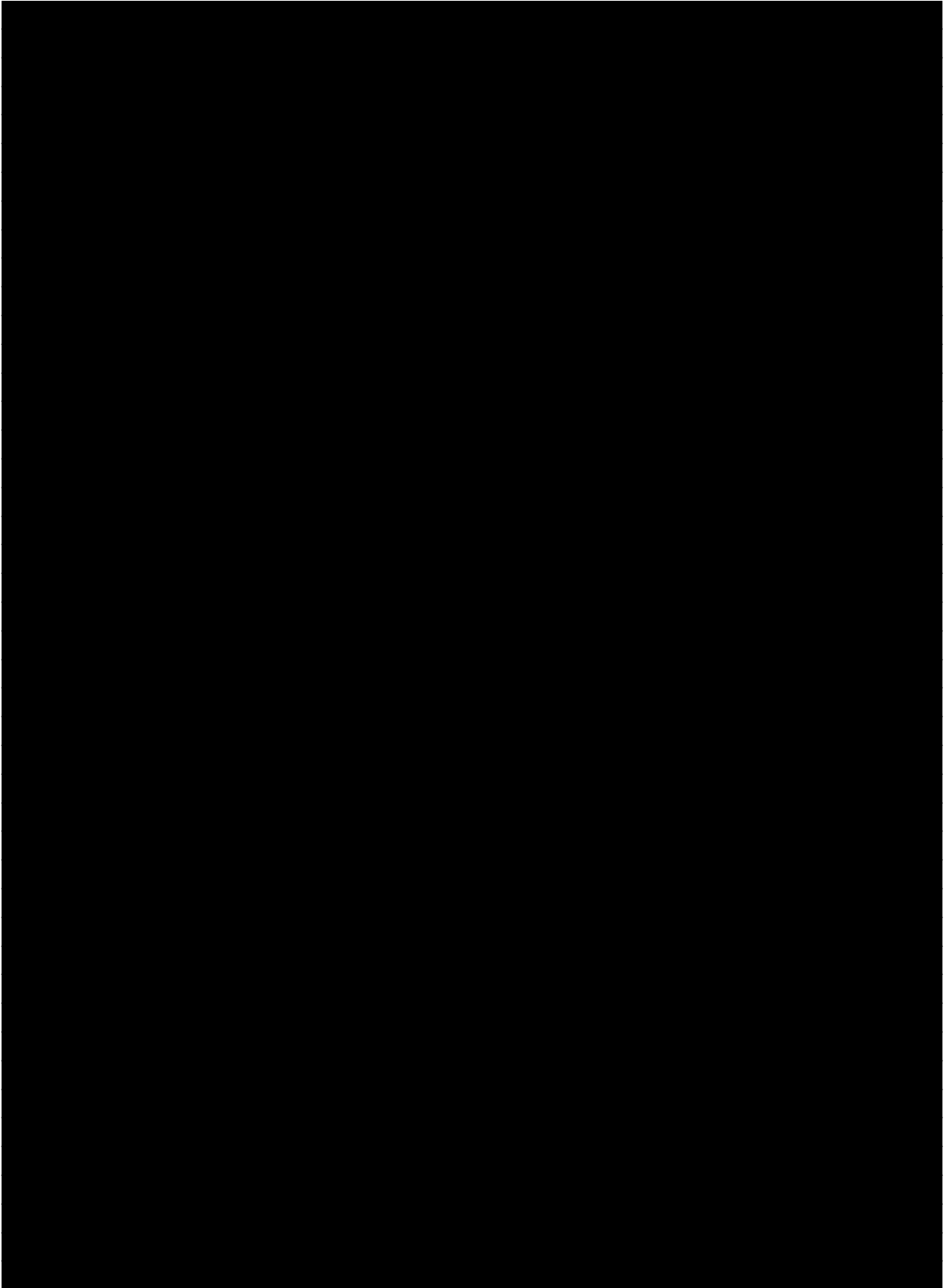












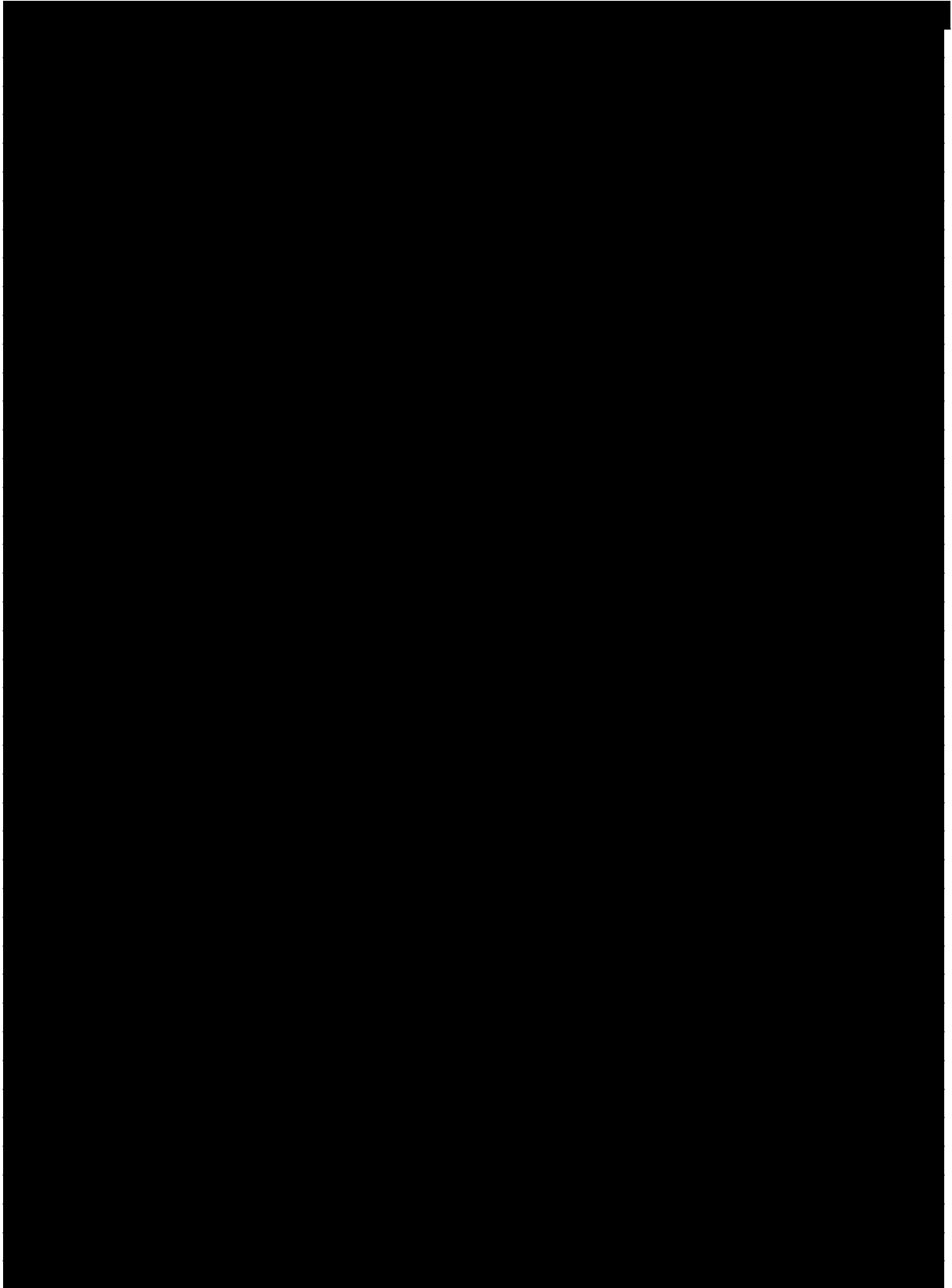


At the hearing, the Appellant's daughter and son, disputed the Plan's findings that the split shift is not medically necessary. The Appellant's daughter testified that their mother is bed-ridden, and at night, she does not sleep more than two to four hours consecutively. She goes to the bathroom at least twice a night and has to be changed. She must be moved every three hours in bed to prevent soars. She had a stroke a year and a half ago and cannot do anything for herself. She fell in February 2018 and was admitted to a hospital and then discharged to a nursing home for recovery before returning home, as indicated in the Plan's assessment. They also presented proof that they currently pay an aid out-of-pocket to stay with their mother at night during the week. On the weekends, the Appellant's son stays overnight with her. The Appellant's children also presented a letter from the Appellant's doctor, [REDACTED], MD, dated May 29, 2018, who writes that the Appellant is unable to get out of bed and she is diagnosed with dementia, heart disease, chronic heart failure and chronic kidney failure.

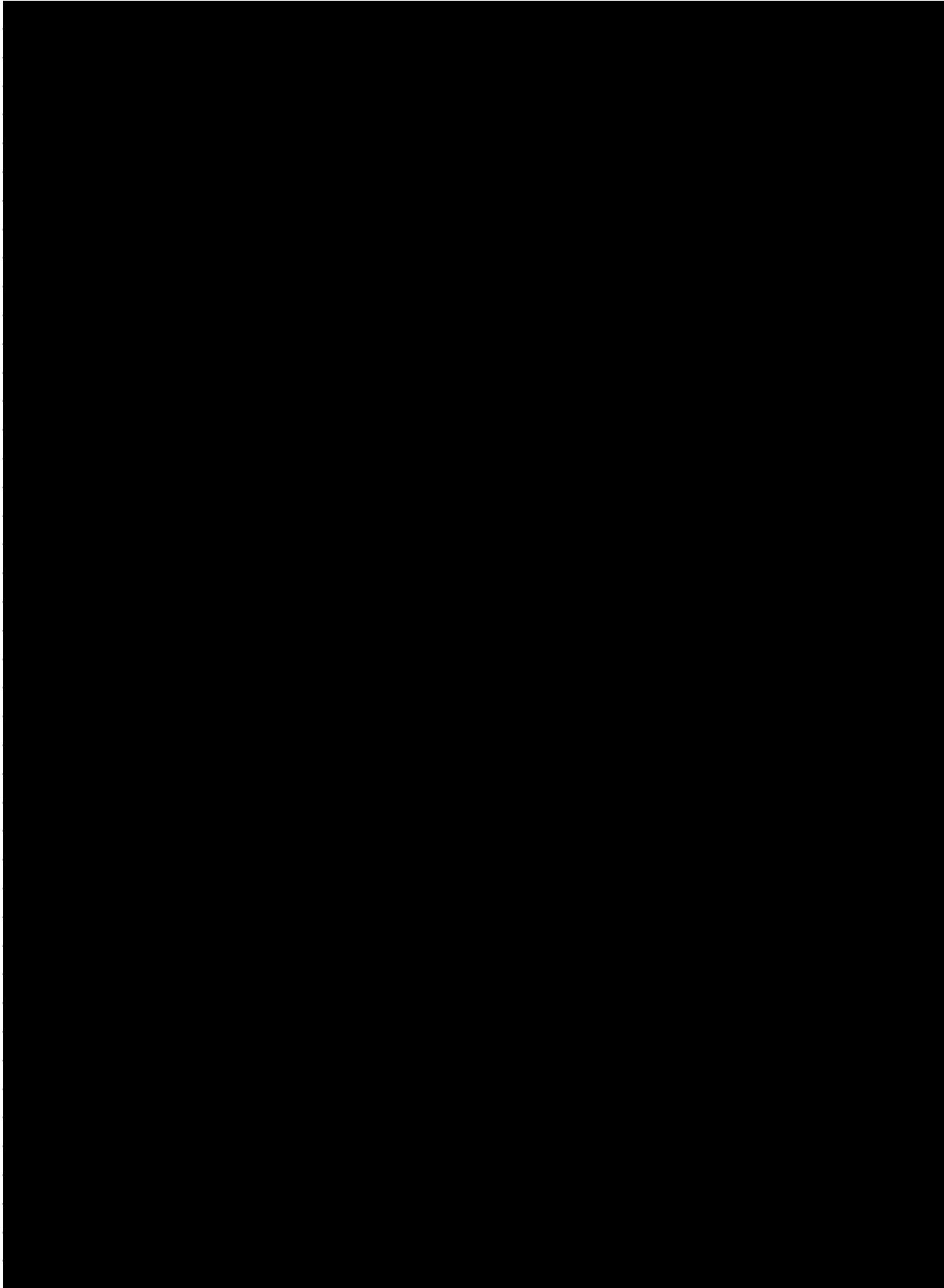
The testimony of the Appellant's children is found to be credible because it was detailed, persuasive and supported by the Plan's case records and other medical documentation presented at the hearing. The record establishes that since Appellant needs to be turned and repositioned in bed and needs night time assistance with toileting, a home attendant would be unable to get five uninterrupted hours of sleep which the regulations require for live-in 24-hour personal care.

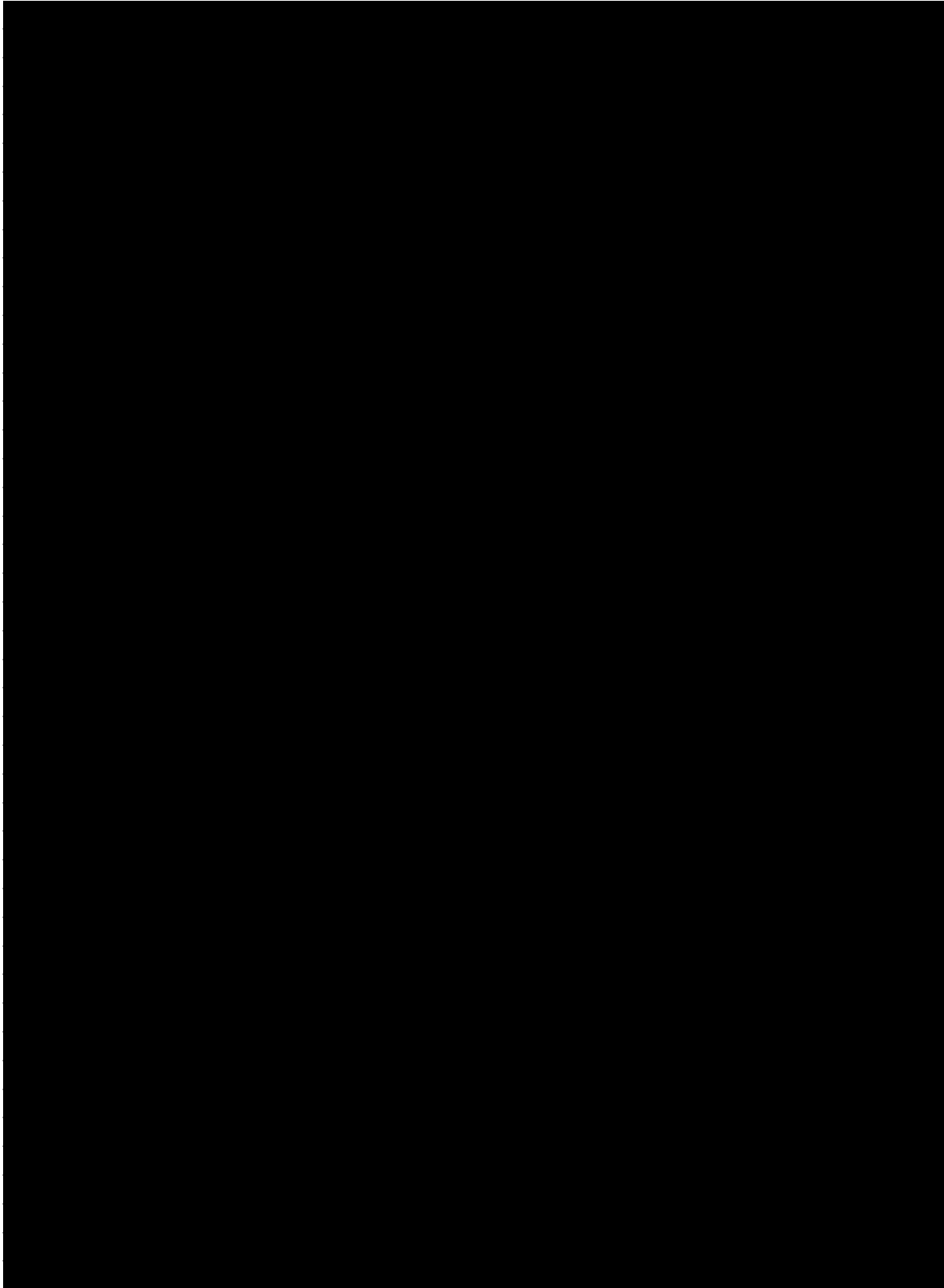
The regulations require that at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance, the Appellant must establish that the denial of assistance or benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits. A review of the record shows that the denial the Appellant's request for increased personal care services from 56 hours per week to 24 hour split shift, 7 days per week was improper and cannot be sustained.

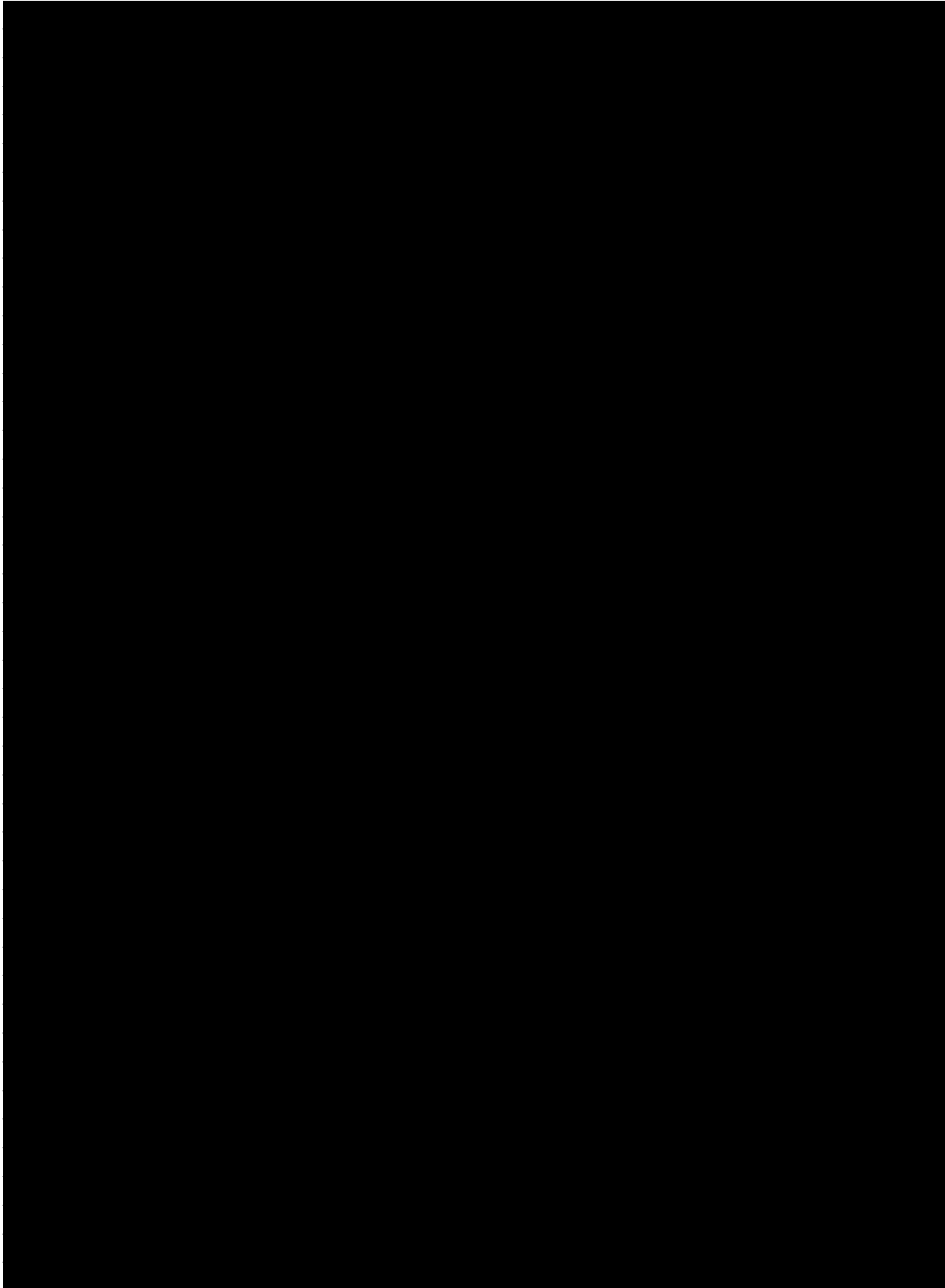
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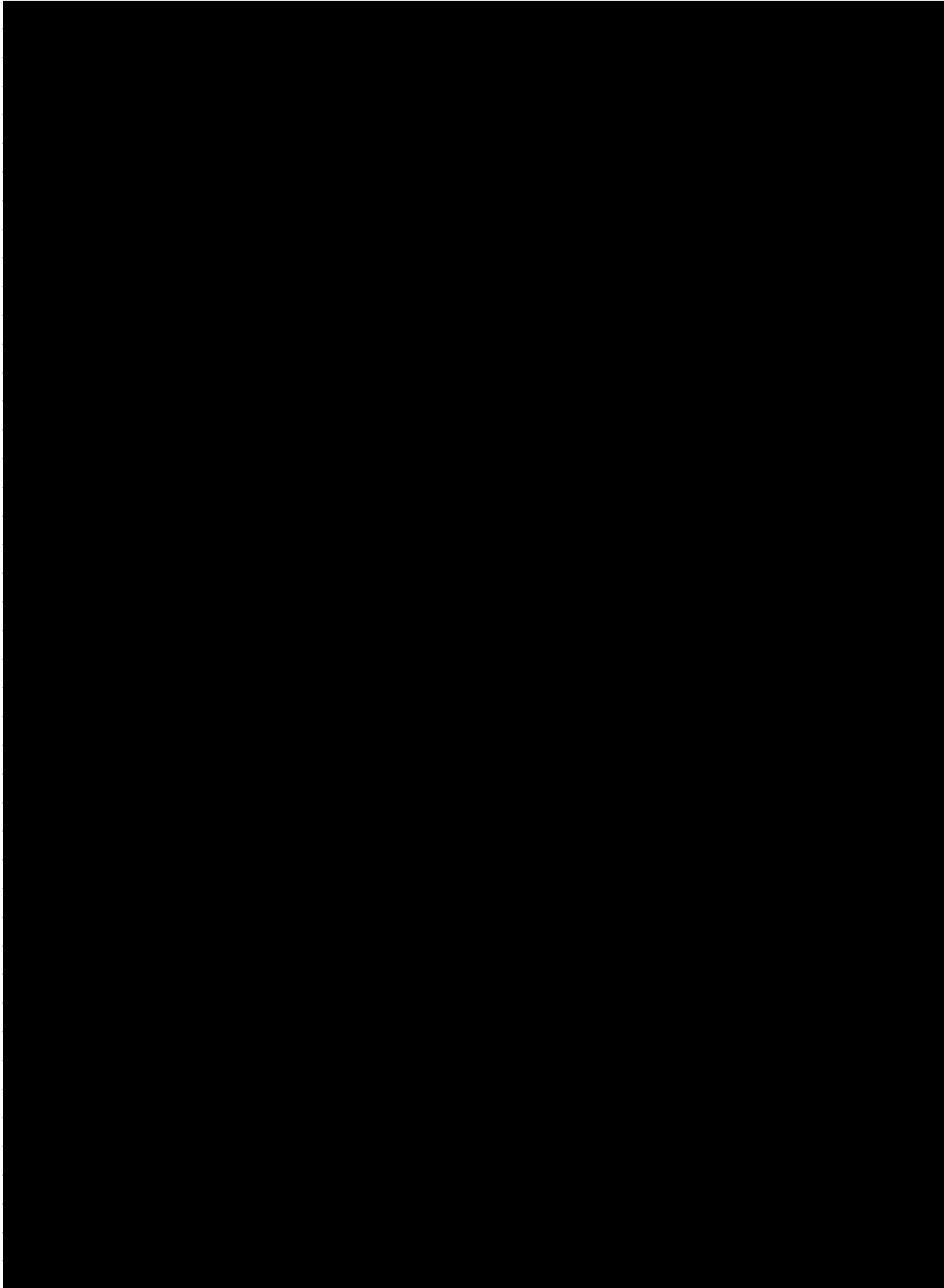


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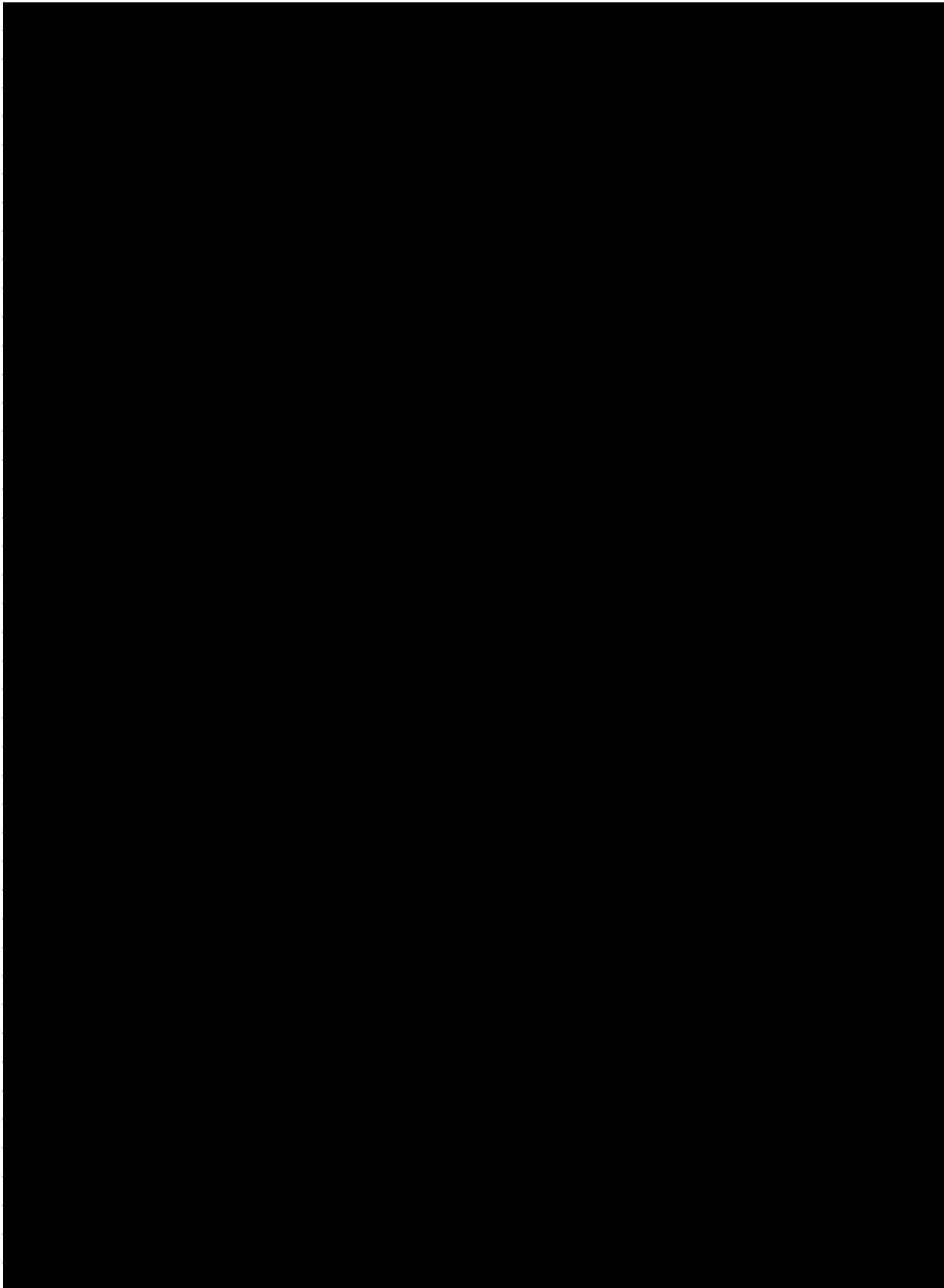




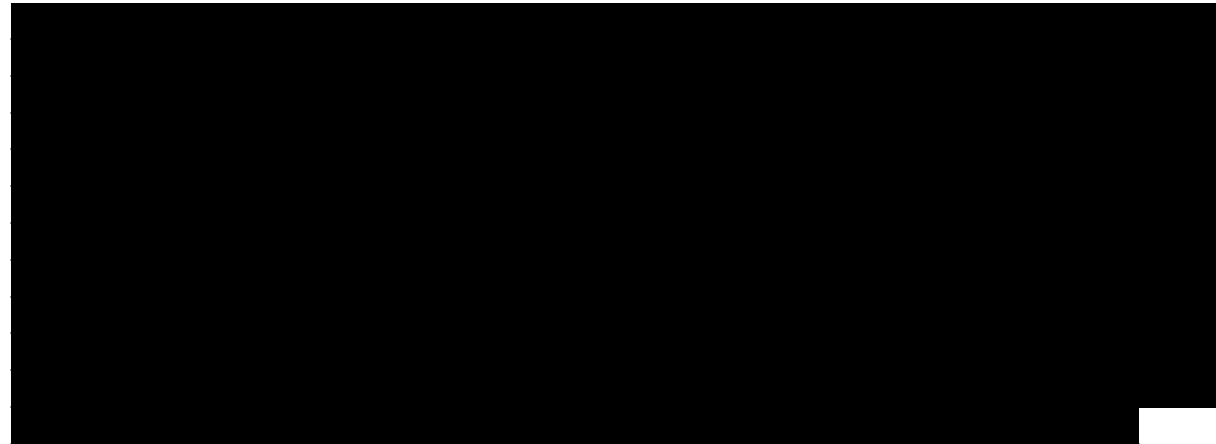




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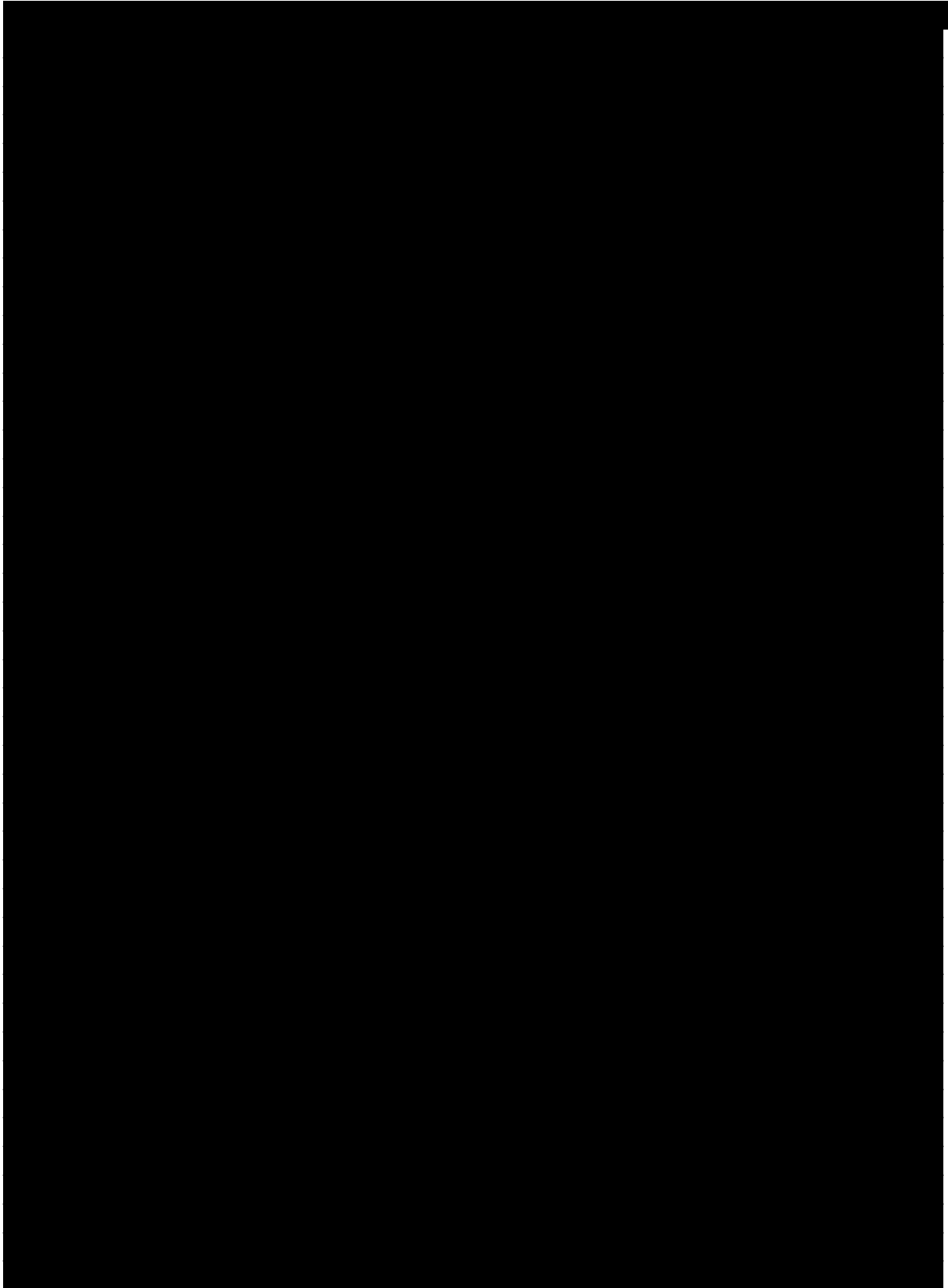


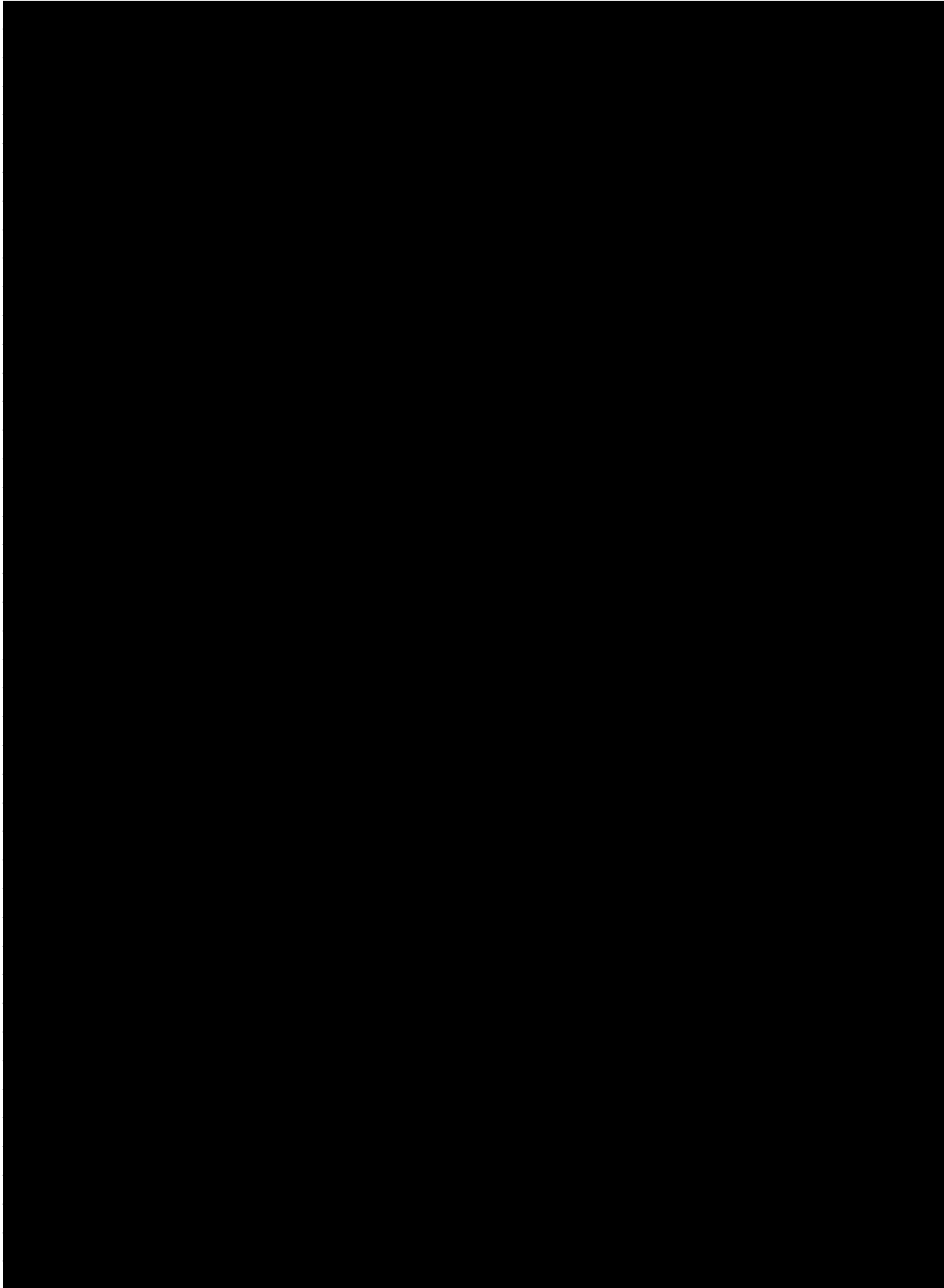
The Plan's March 29, 2018 determination to deny Personal Care Services in the amount of 24 hour continuous care, split shift, 7 days per week is not correct and is reversed.

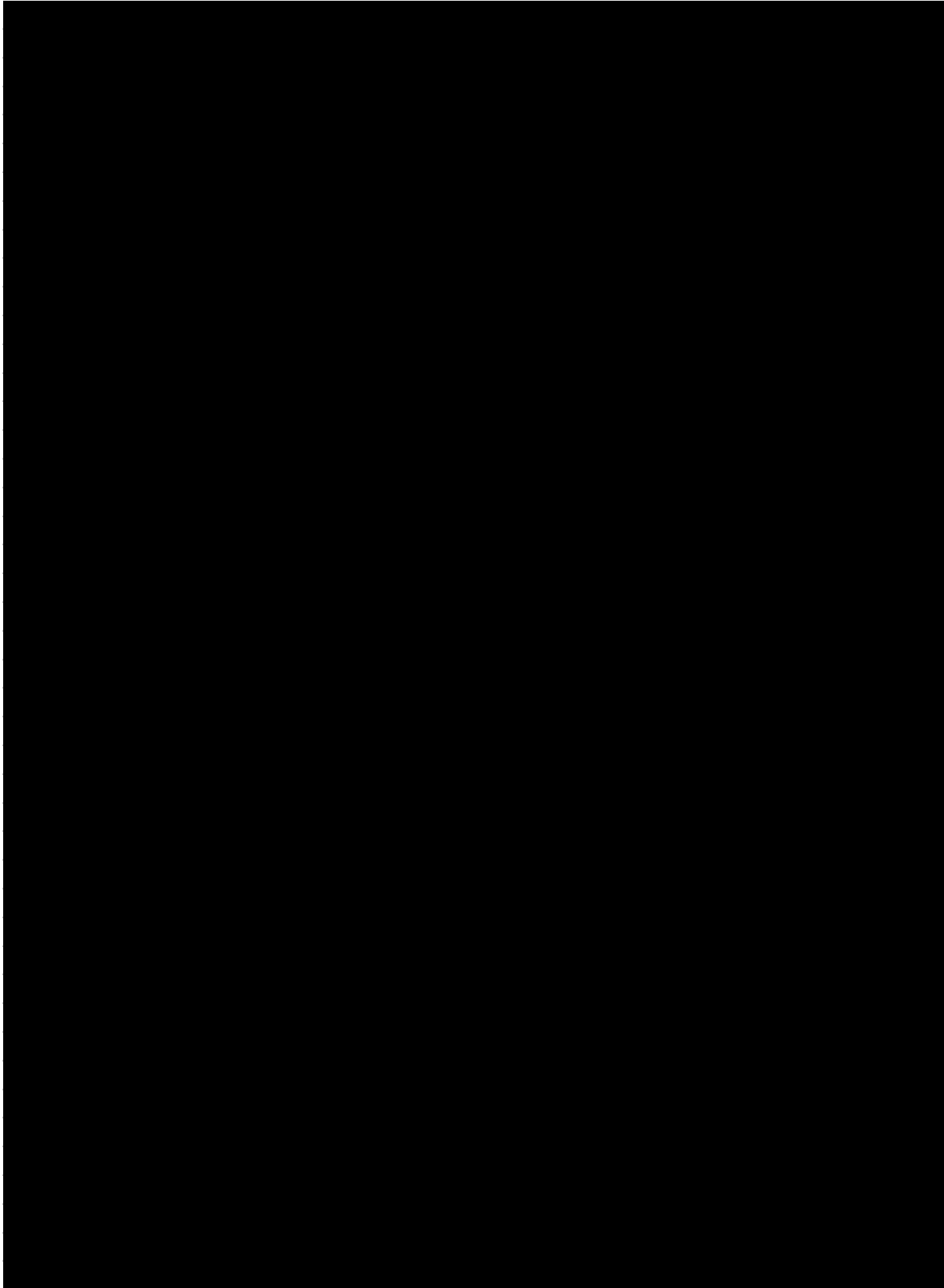
1. The Plan is directed to authorize 24 hour split shift, 7 days per week for Appellant and to notify Appellant and her representatives in writing upon compliance with this decision after fair hearing.

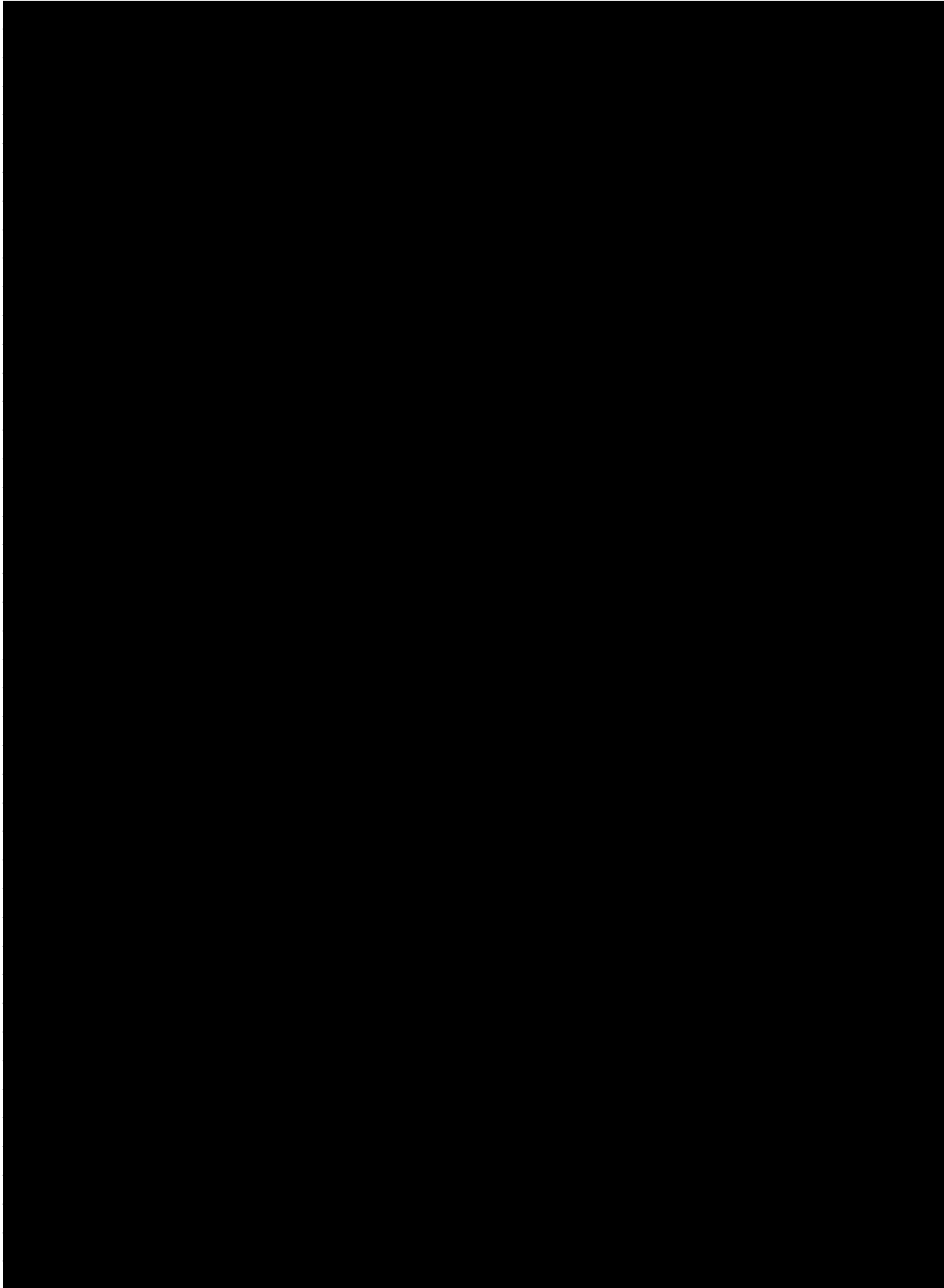
Should the Plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant and her representative promptly in writing as to what documentation is needed. If such information is requested, the Appellant or her representative must provide it to the Plan promptly to facilitate such compliance.

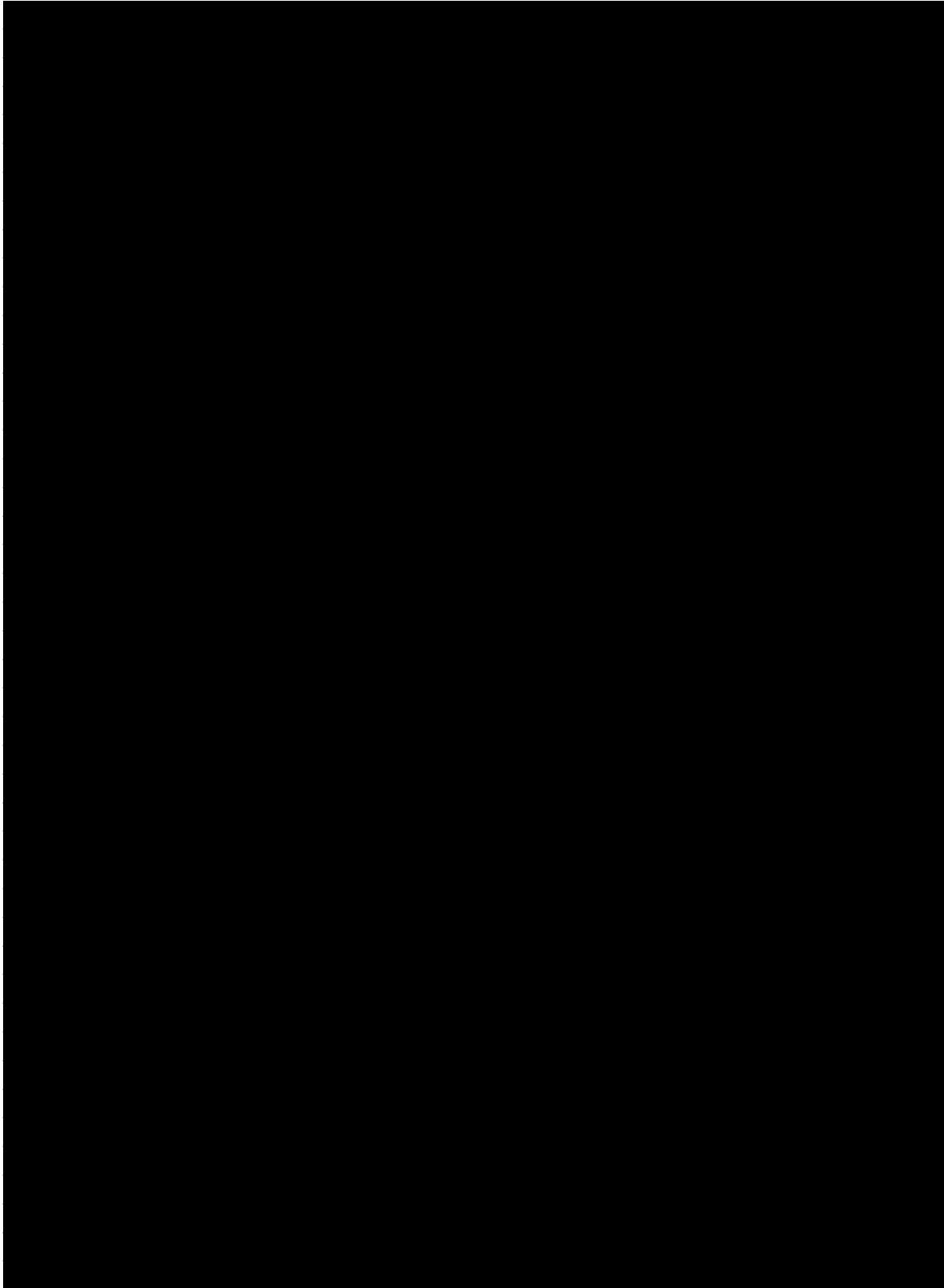
As required by 18 NYCRR 358-6.4, the Plan must comply immediately with the directives set forth above.

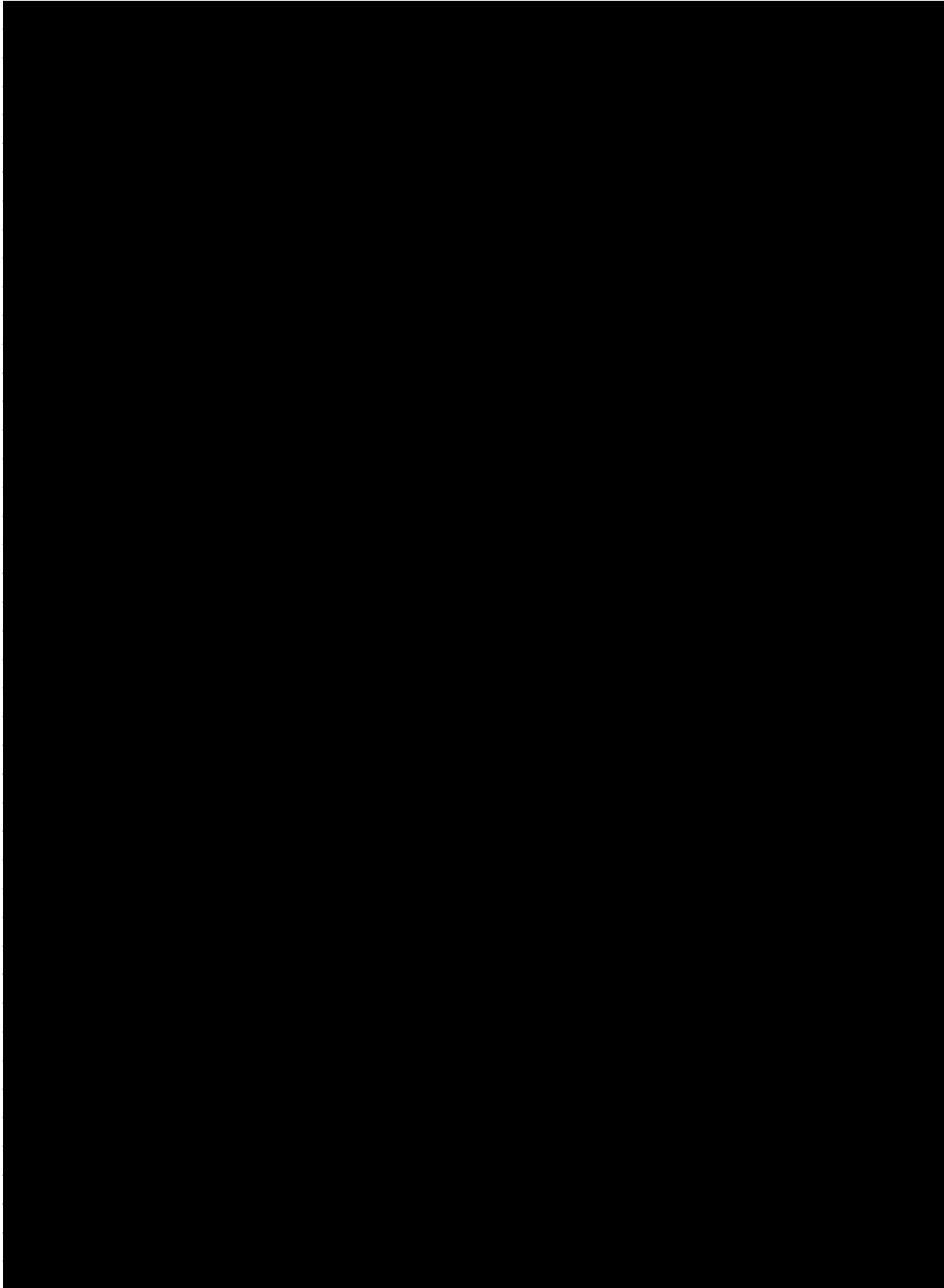


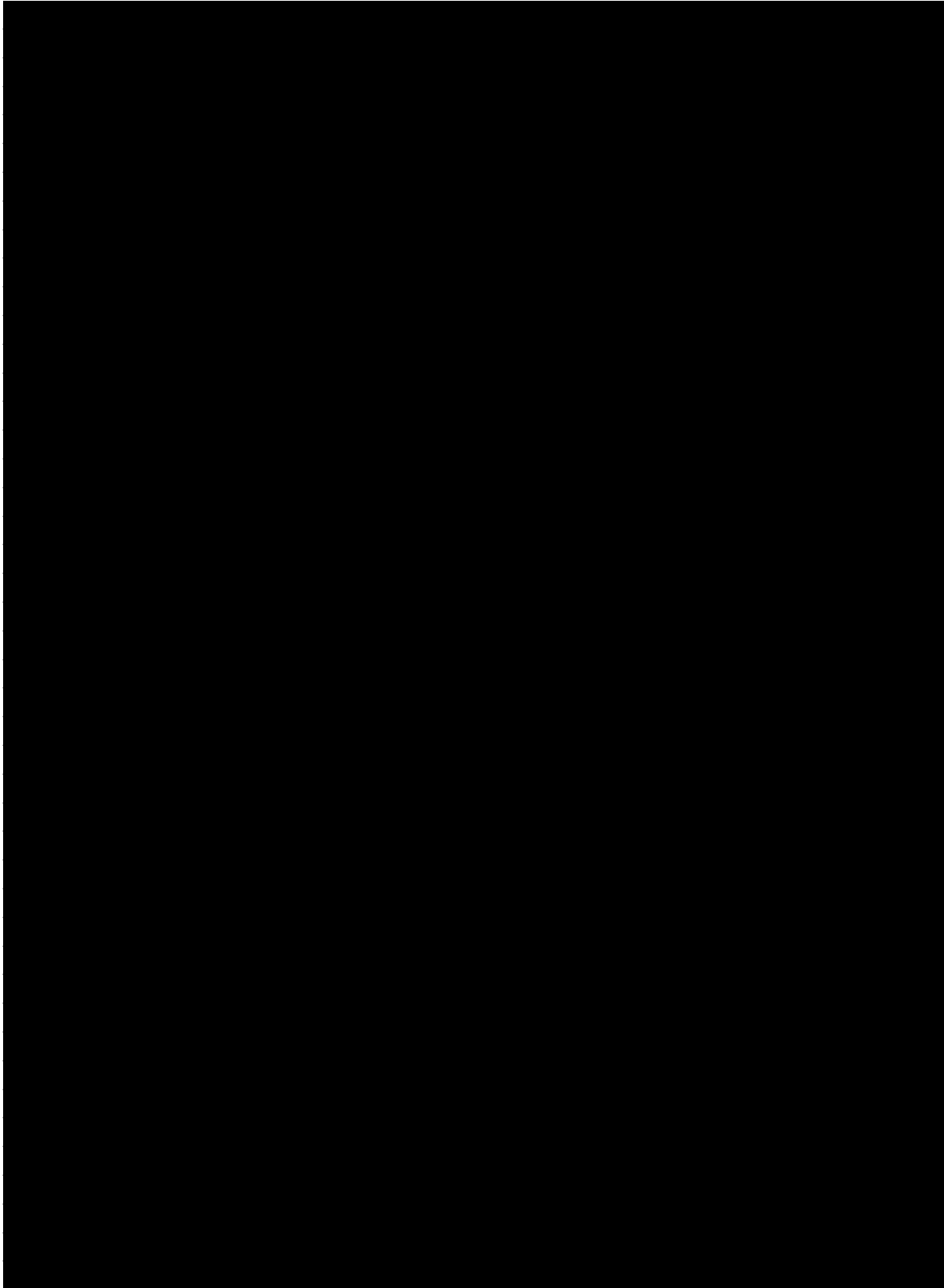




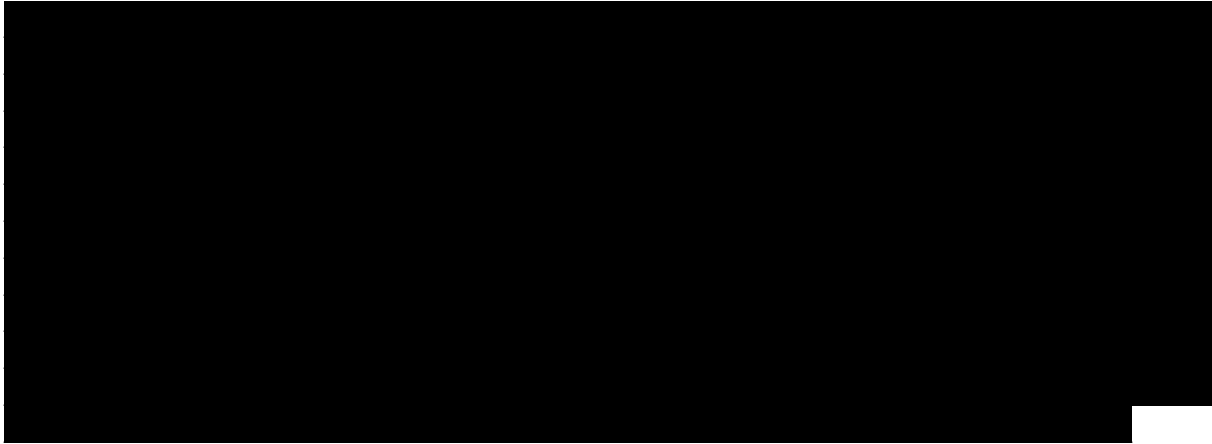






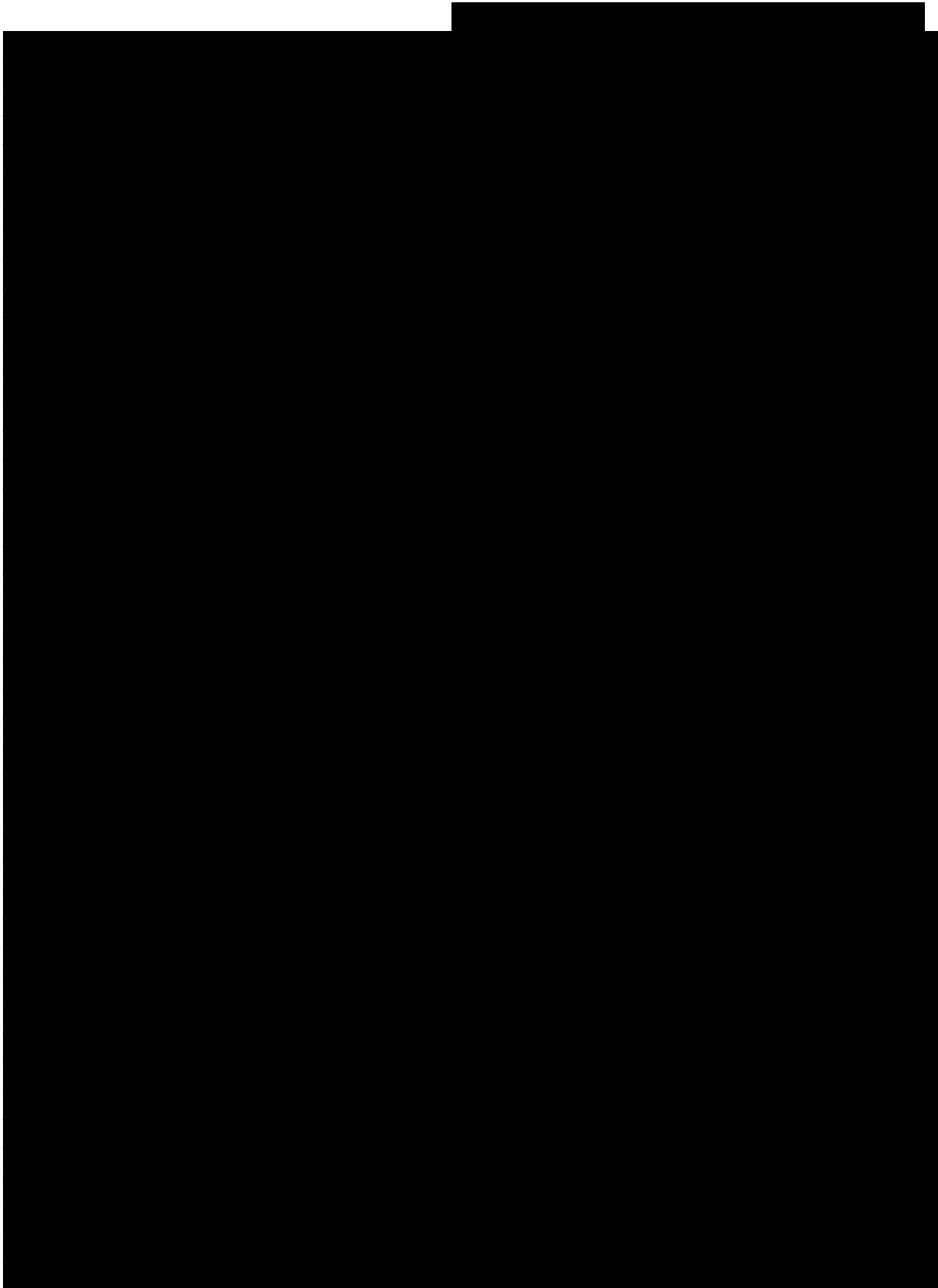


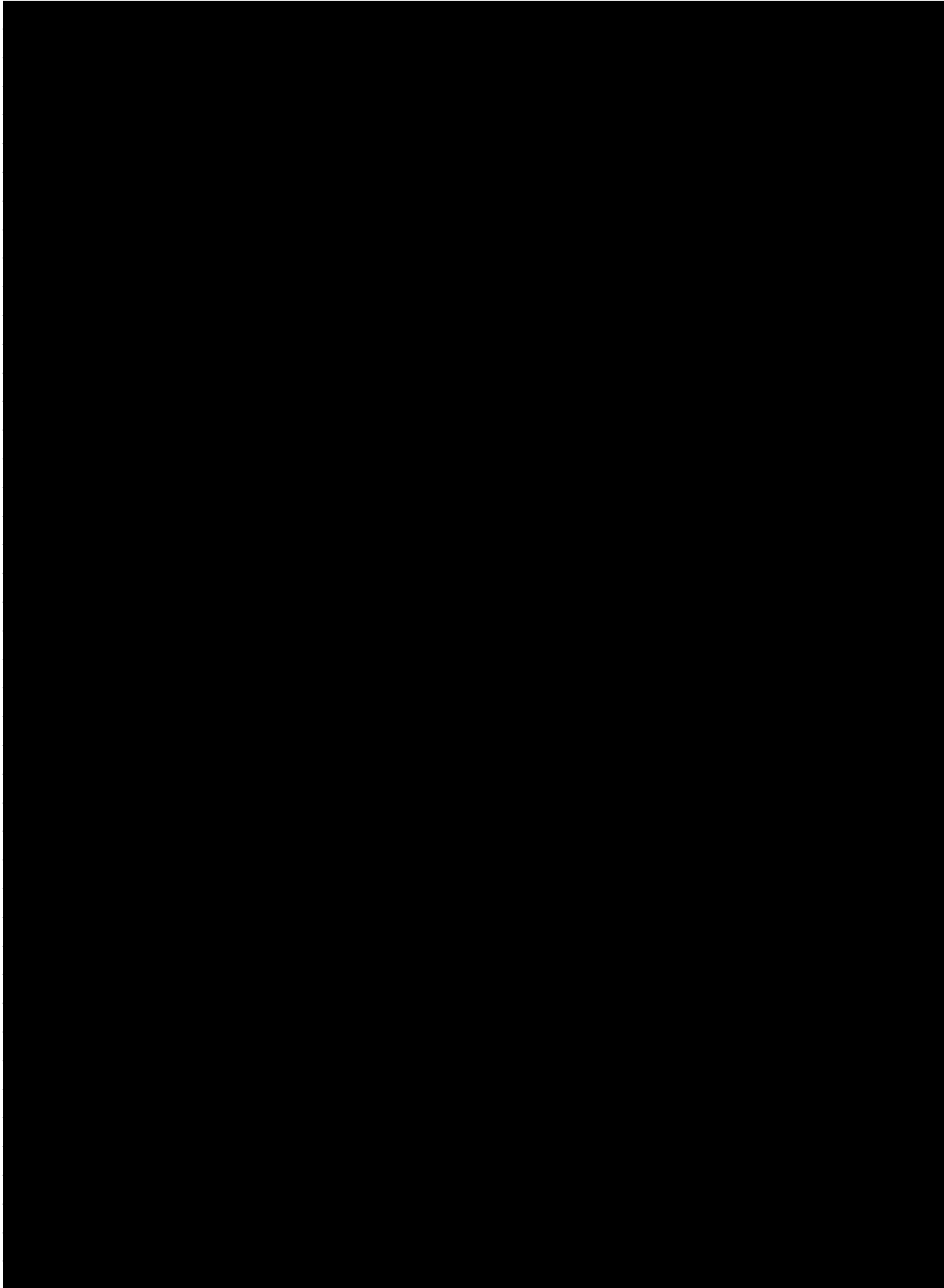
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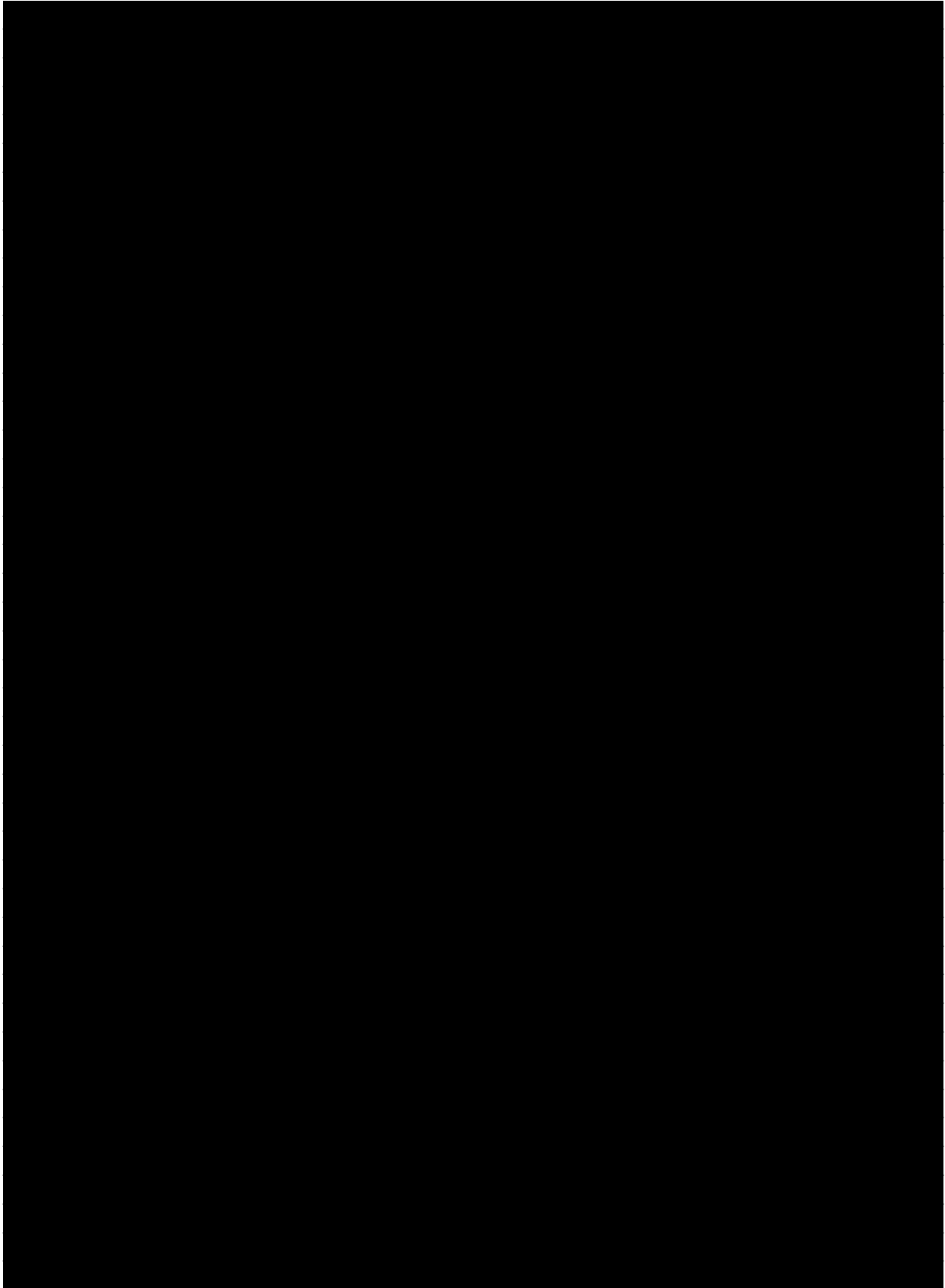


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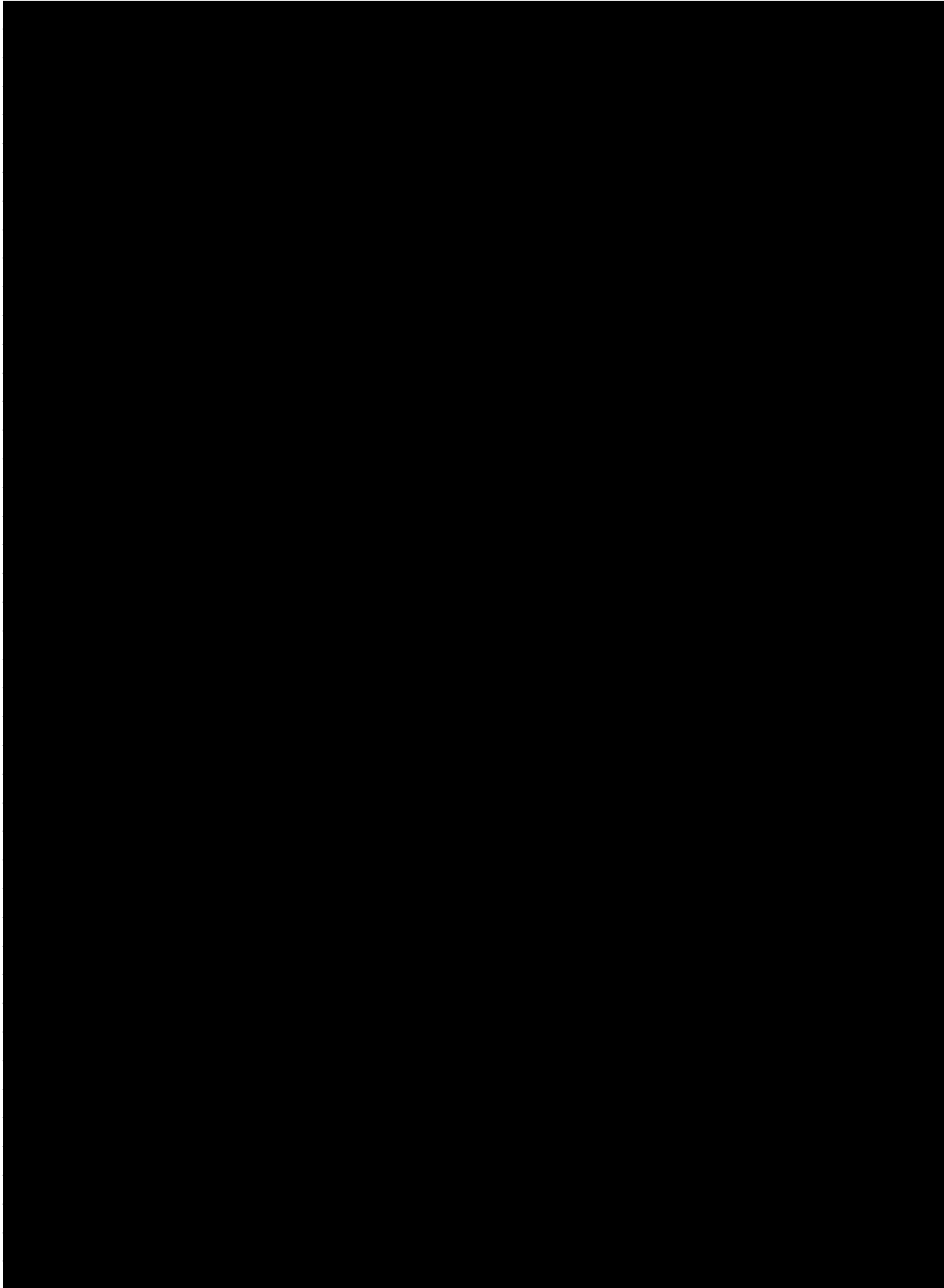
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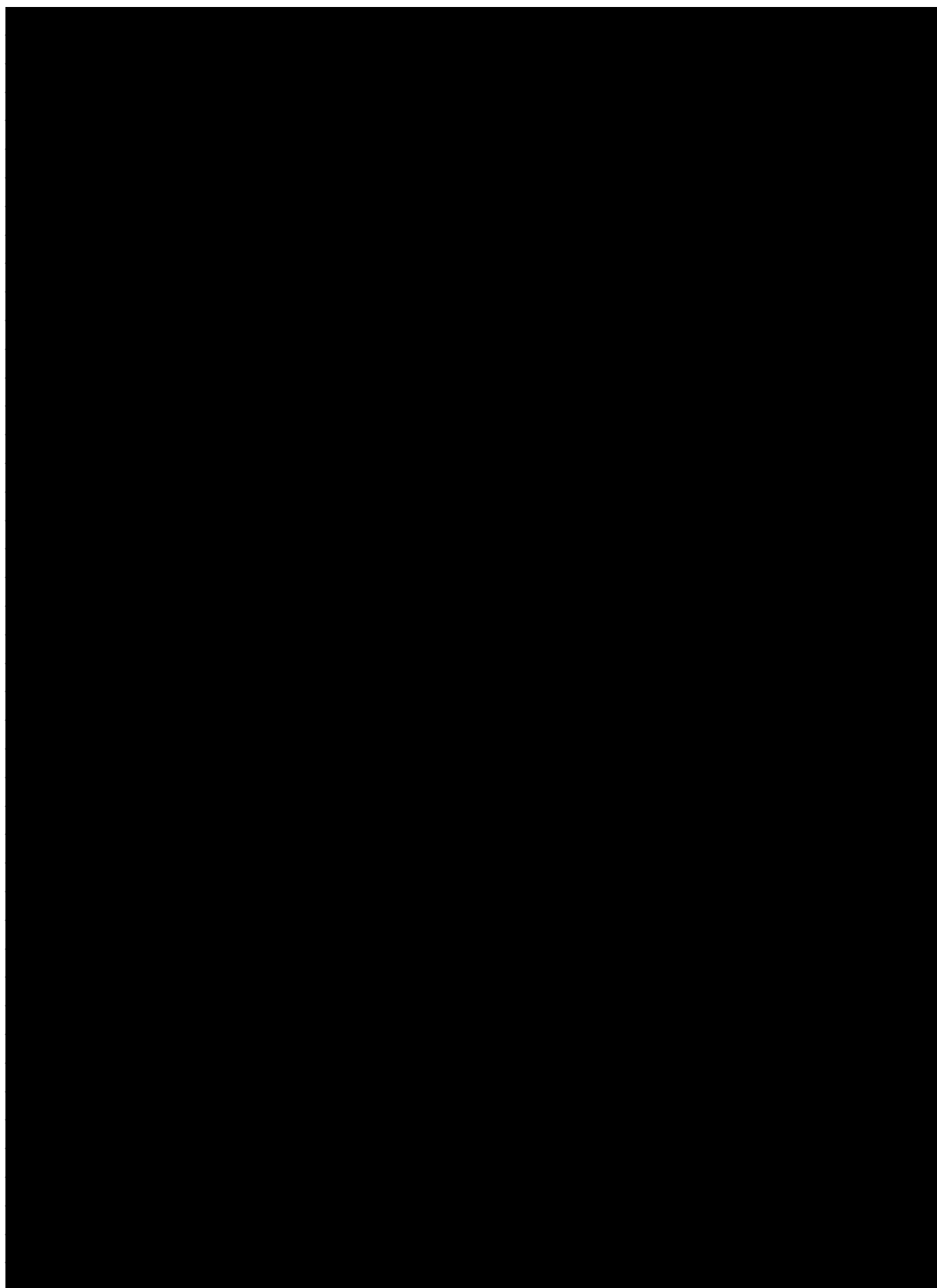


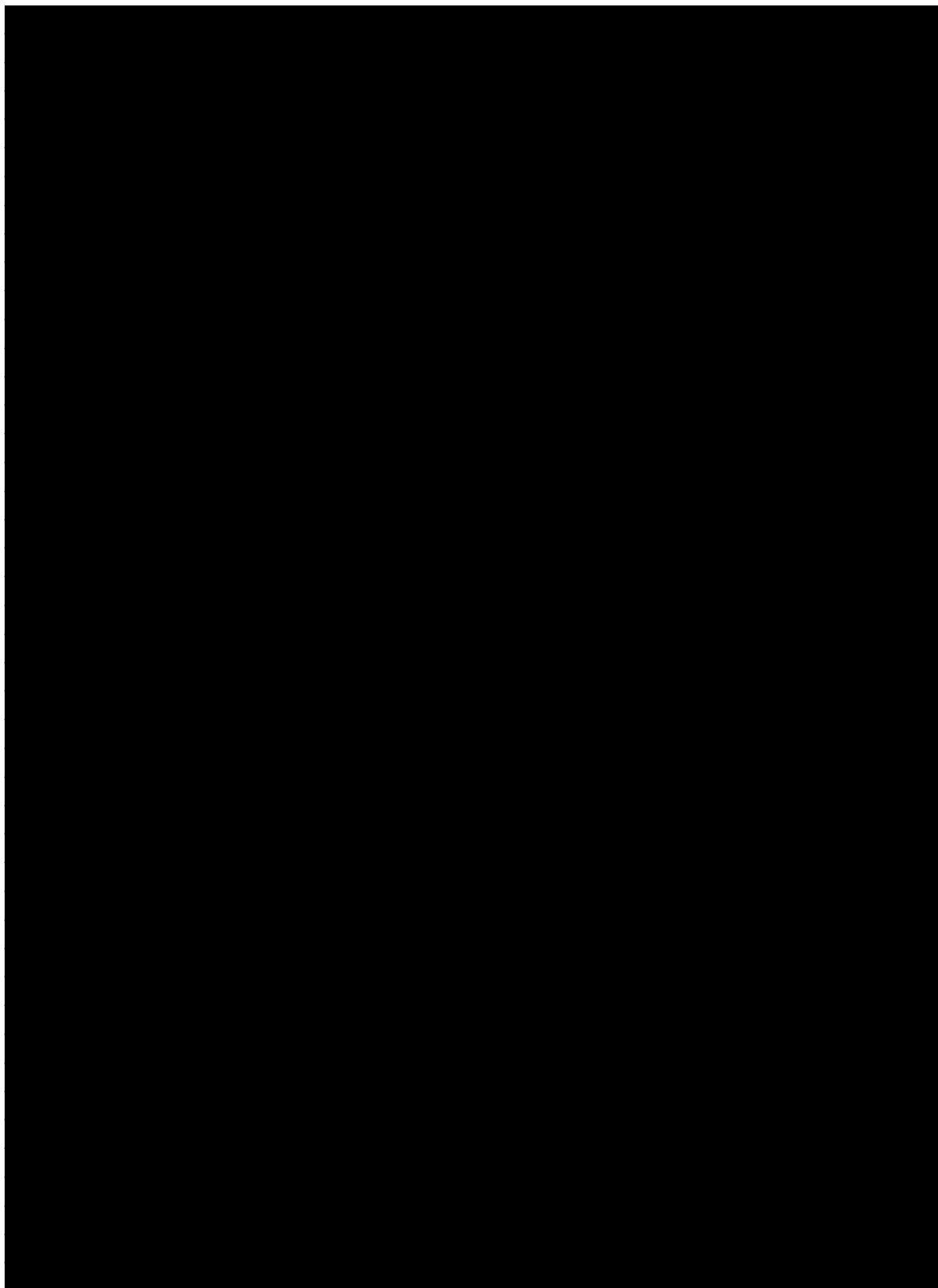


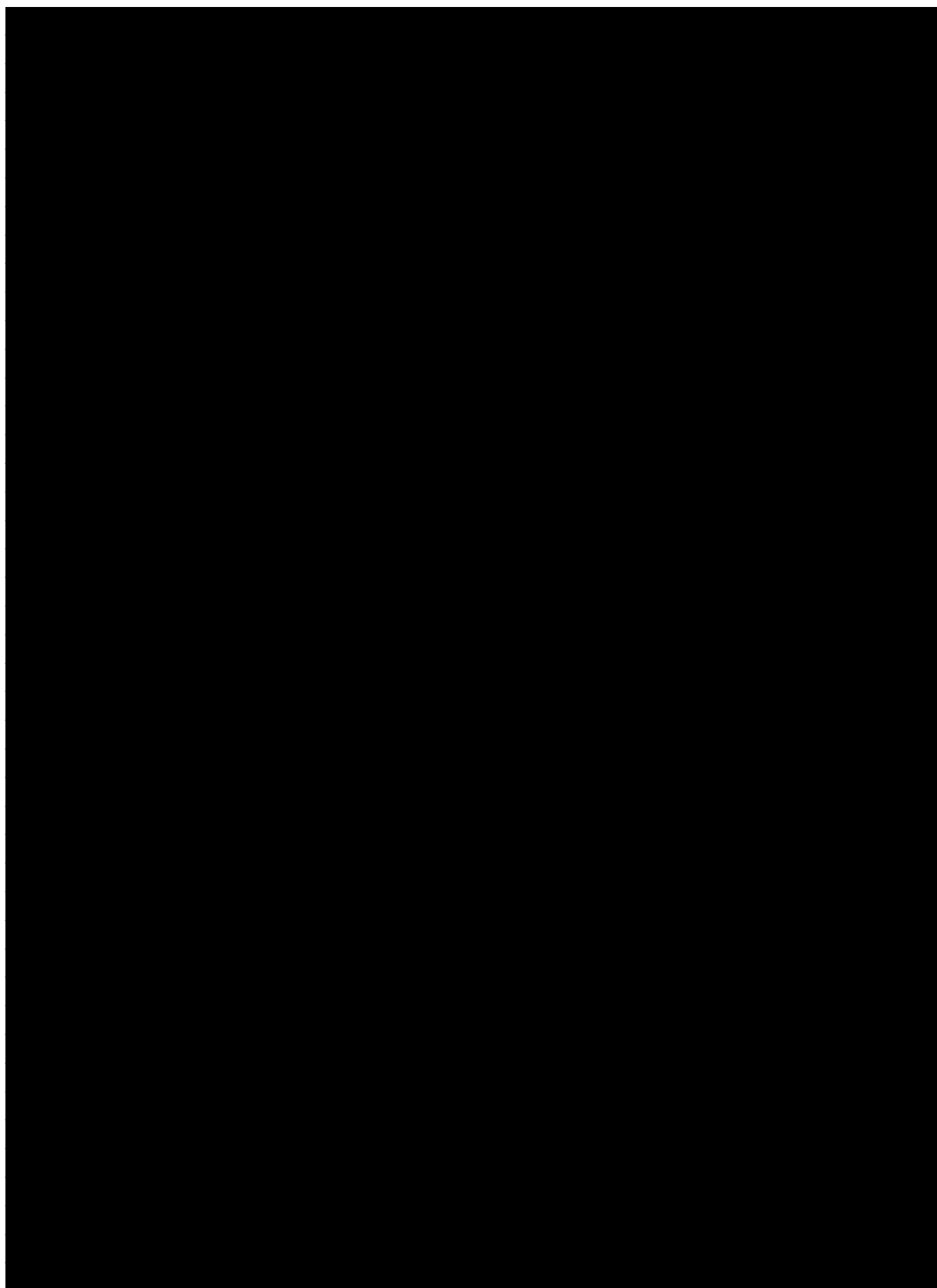


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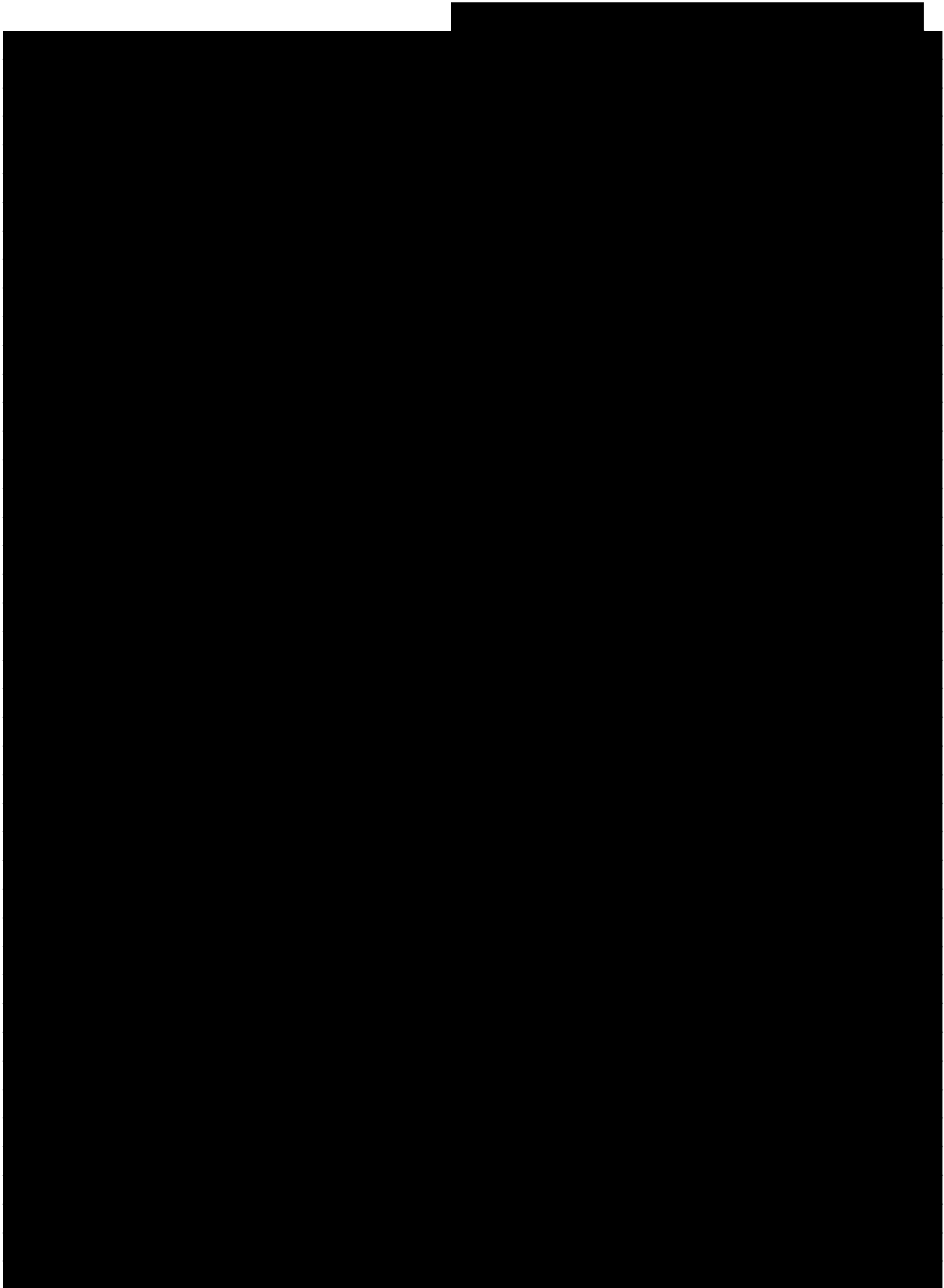


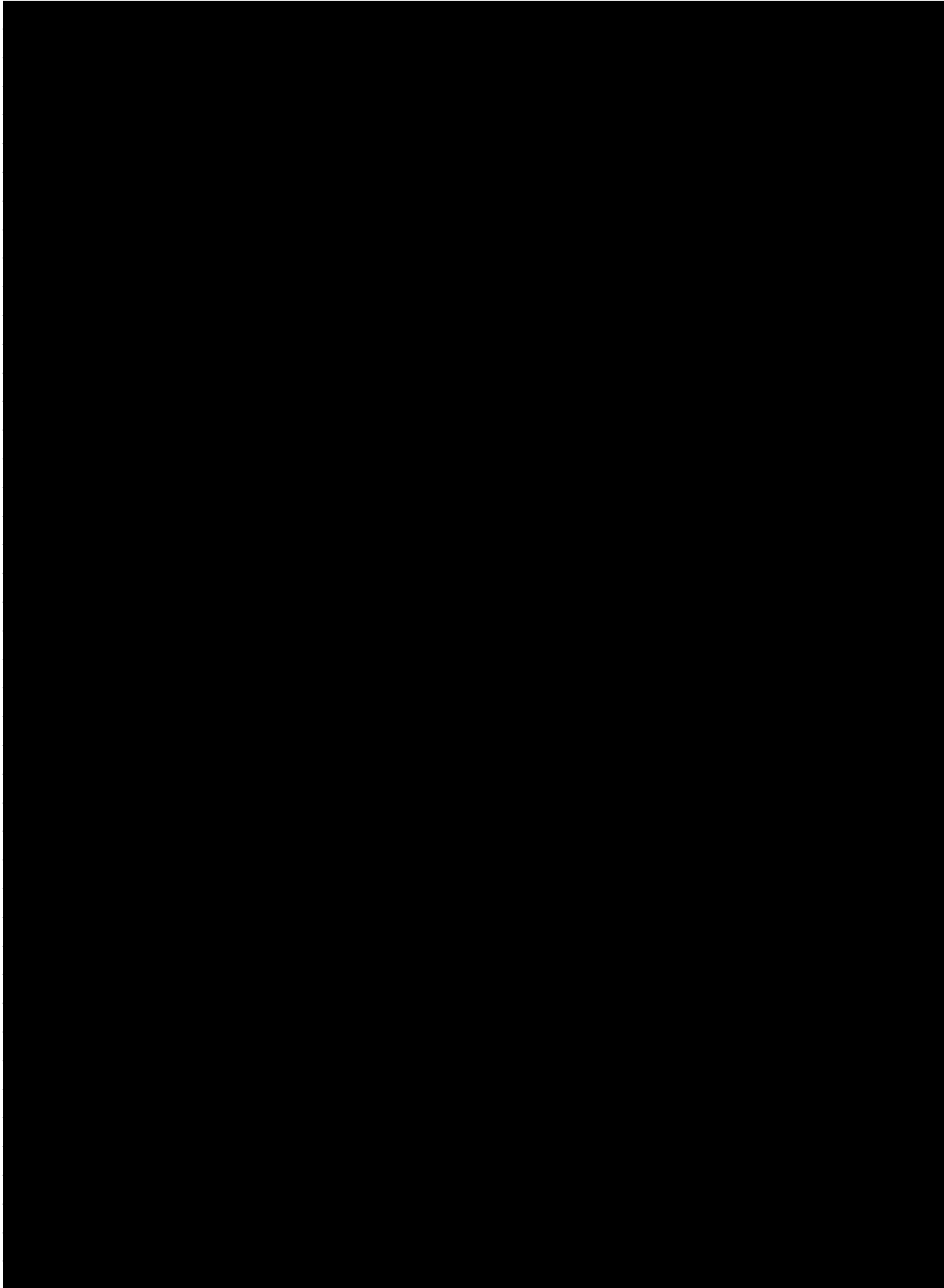


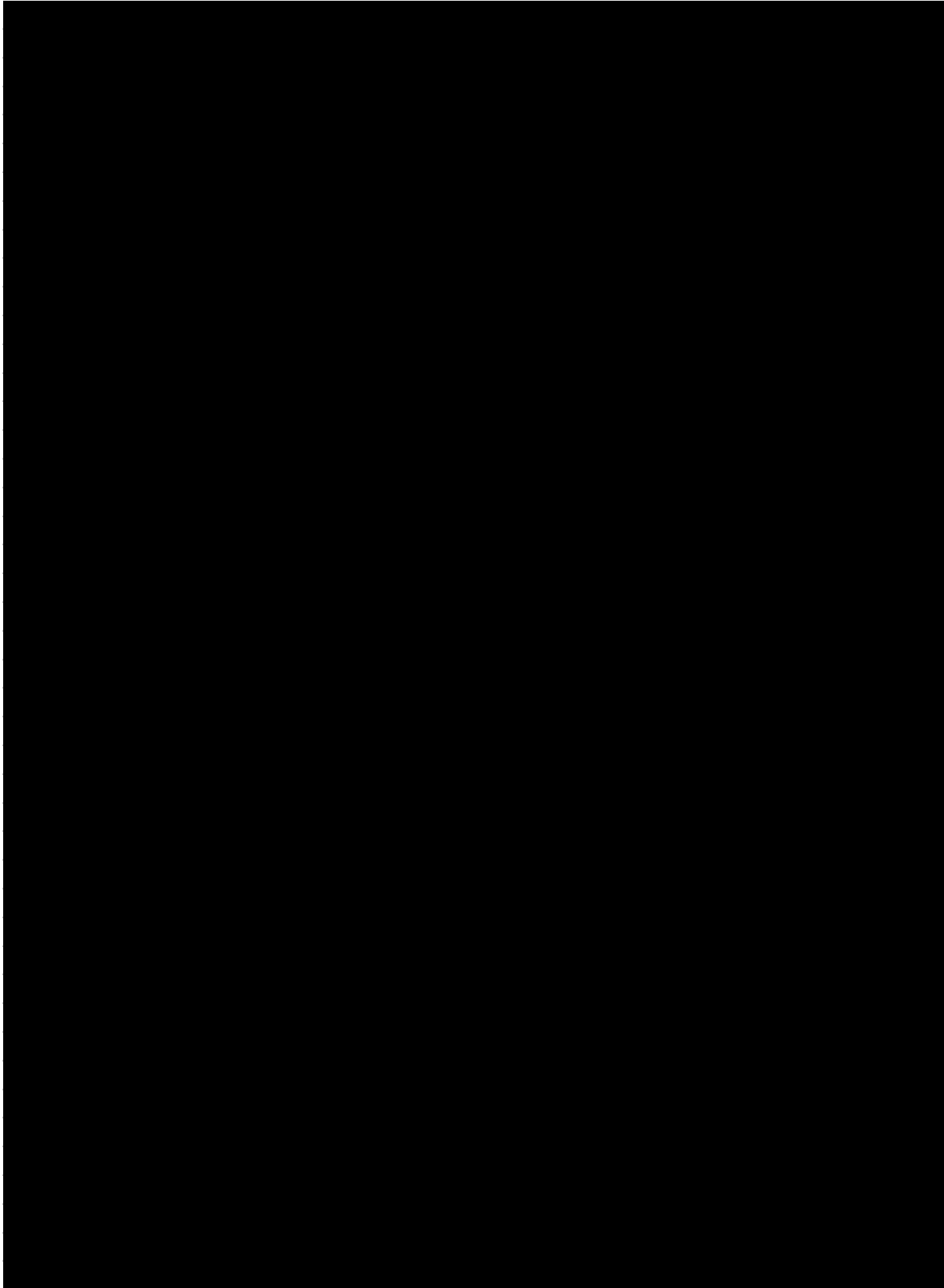
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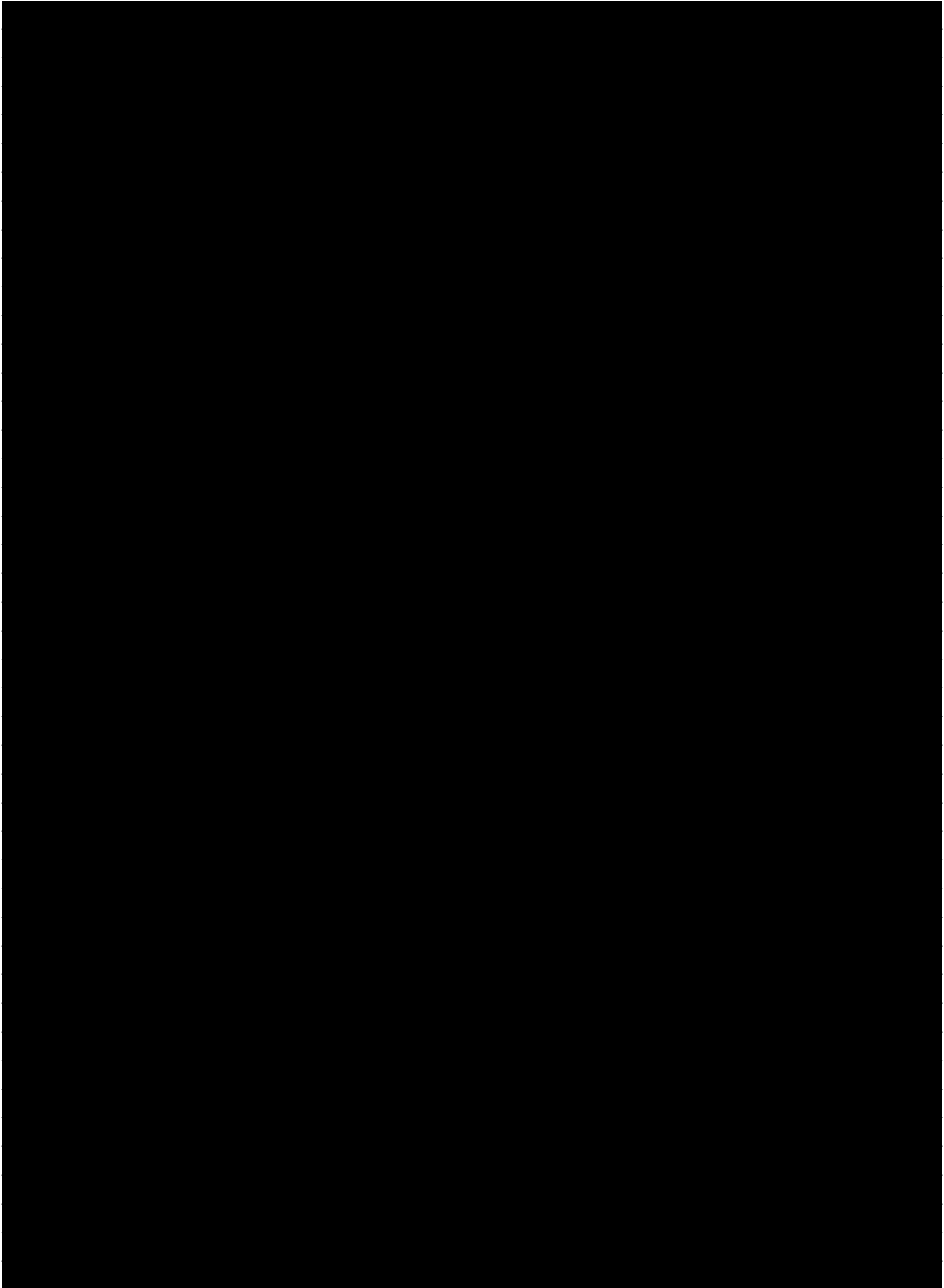
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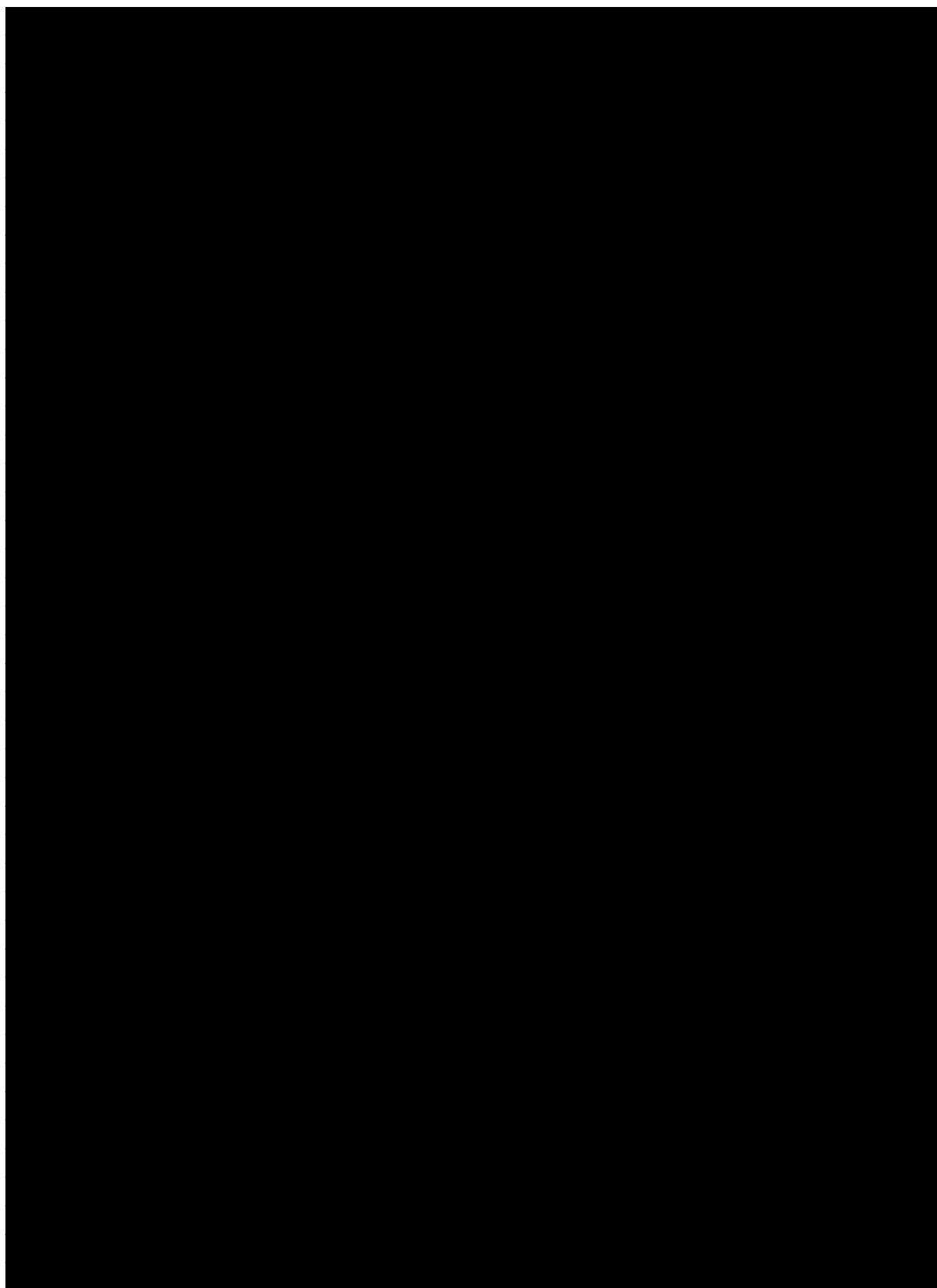




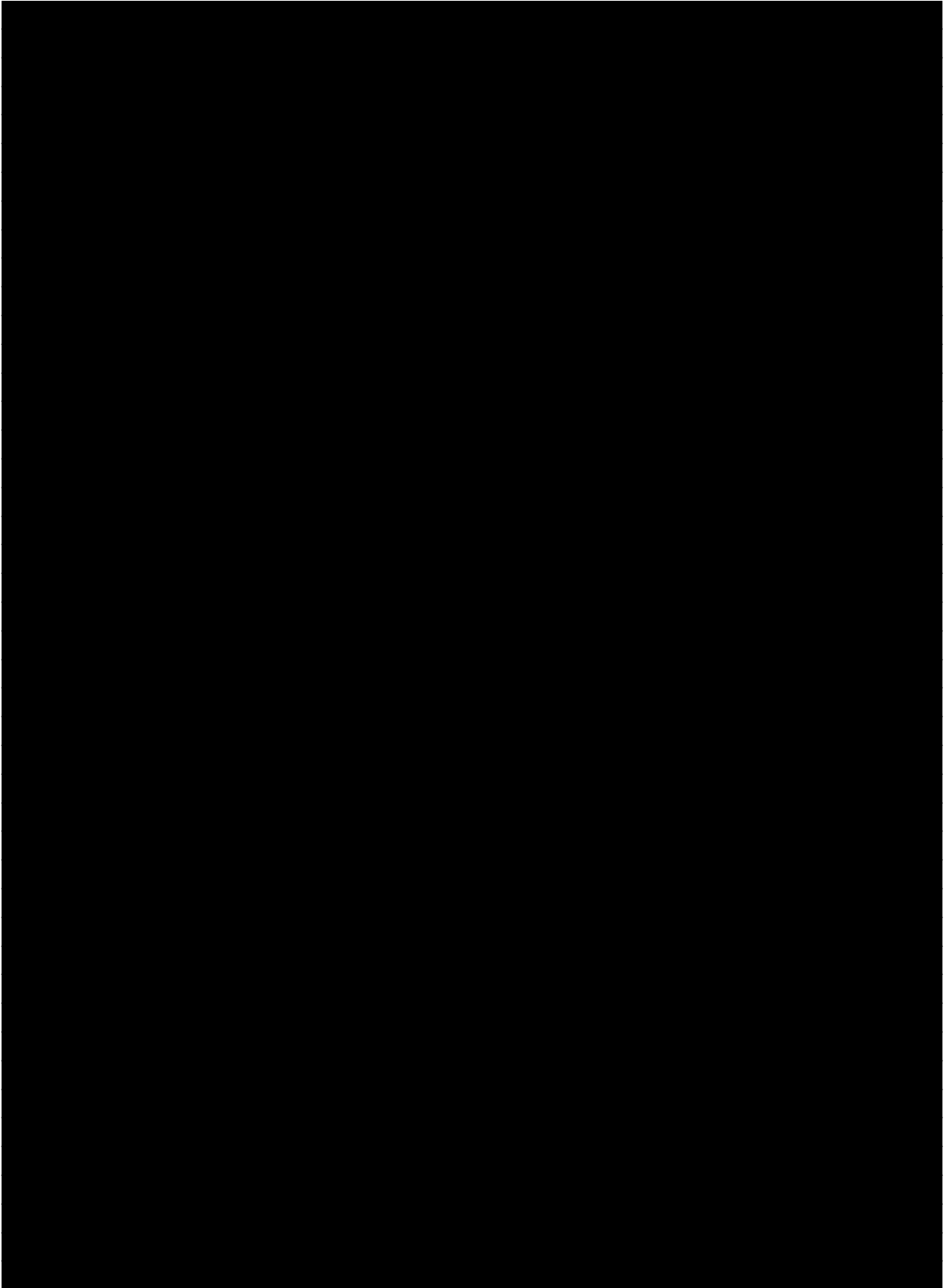








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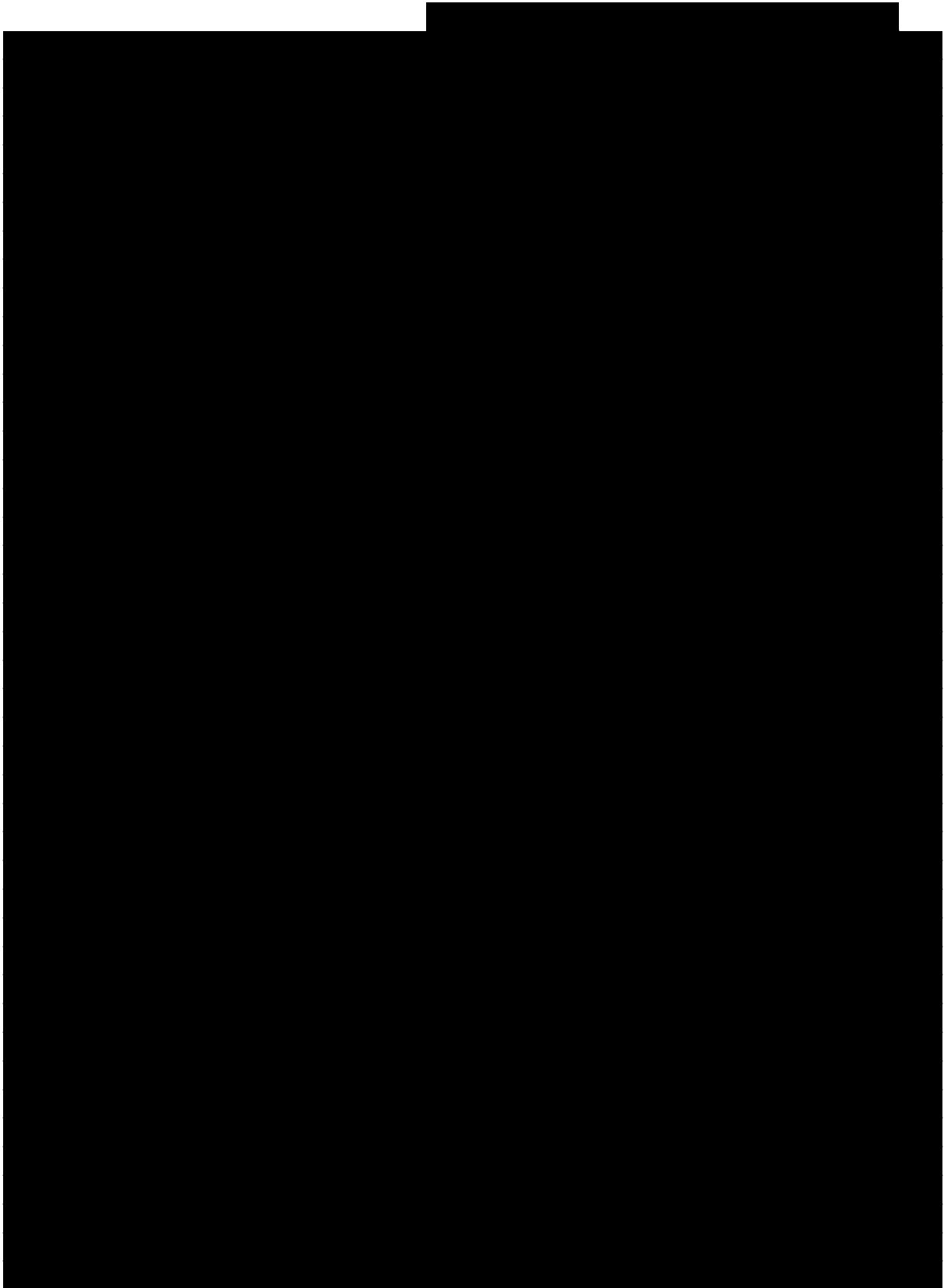


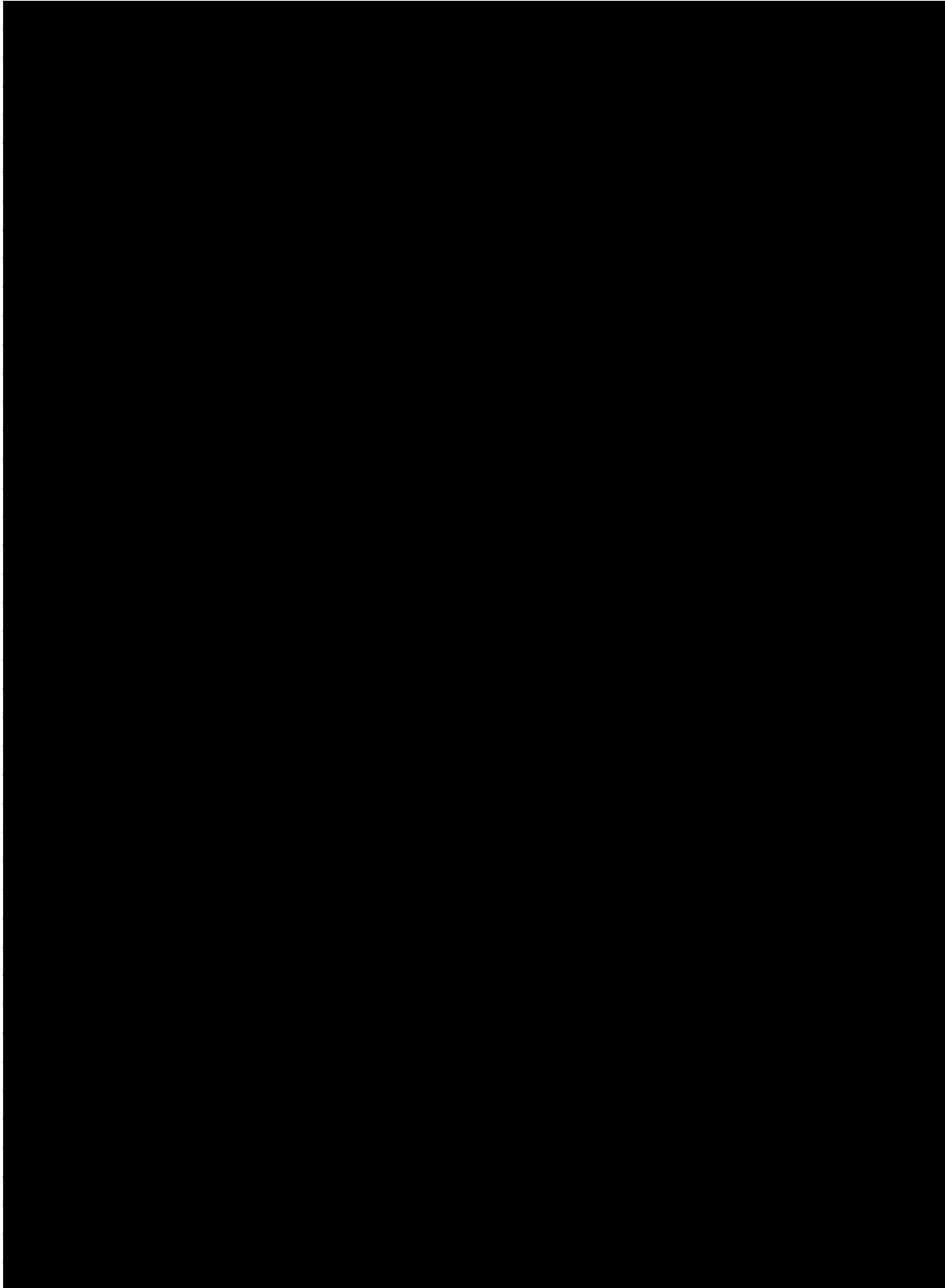
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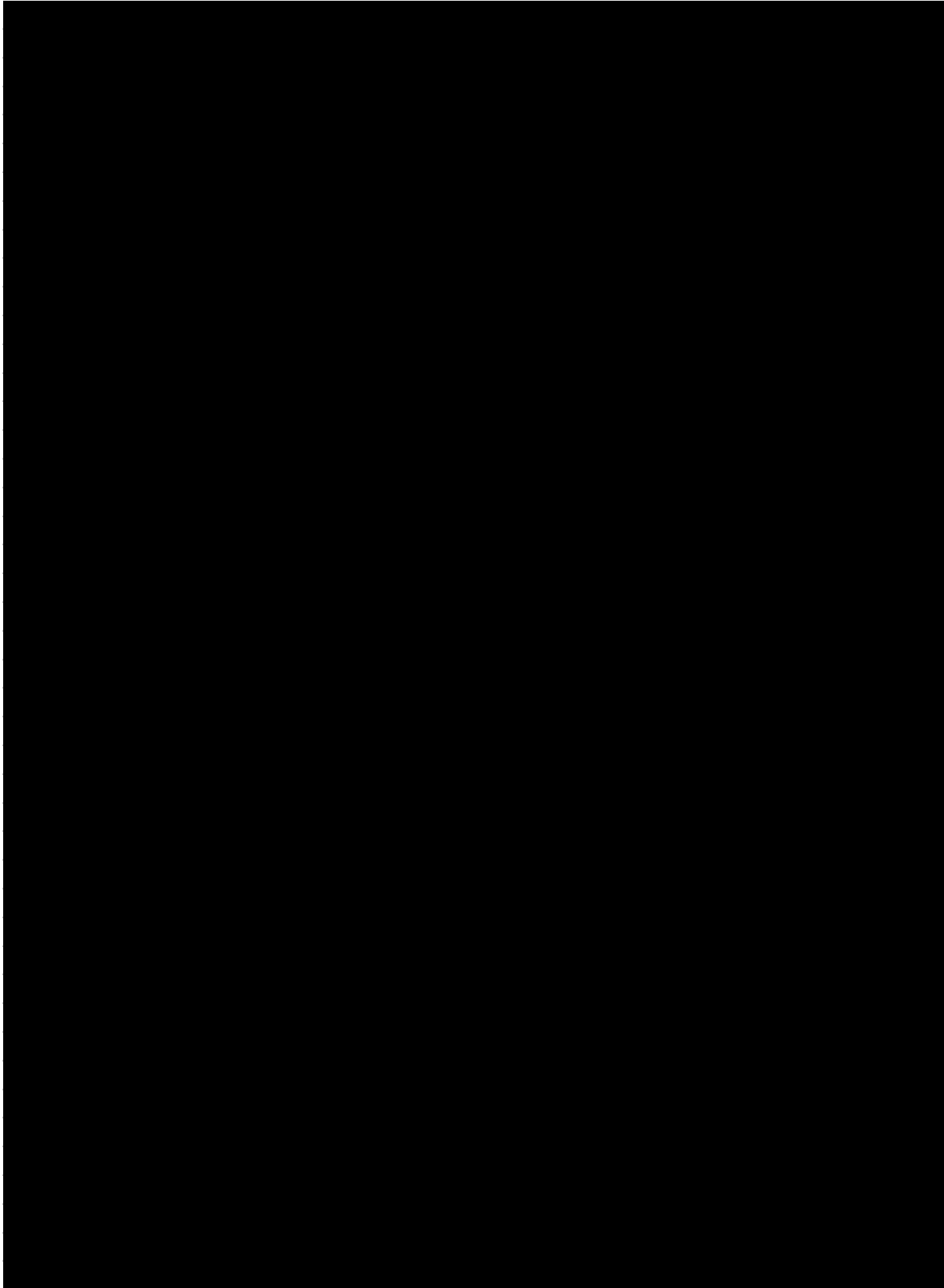


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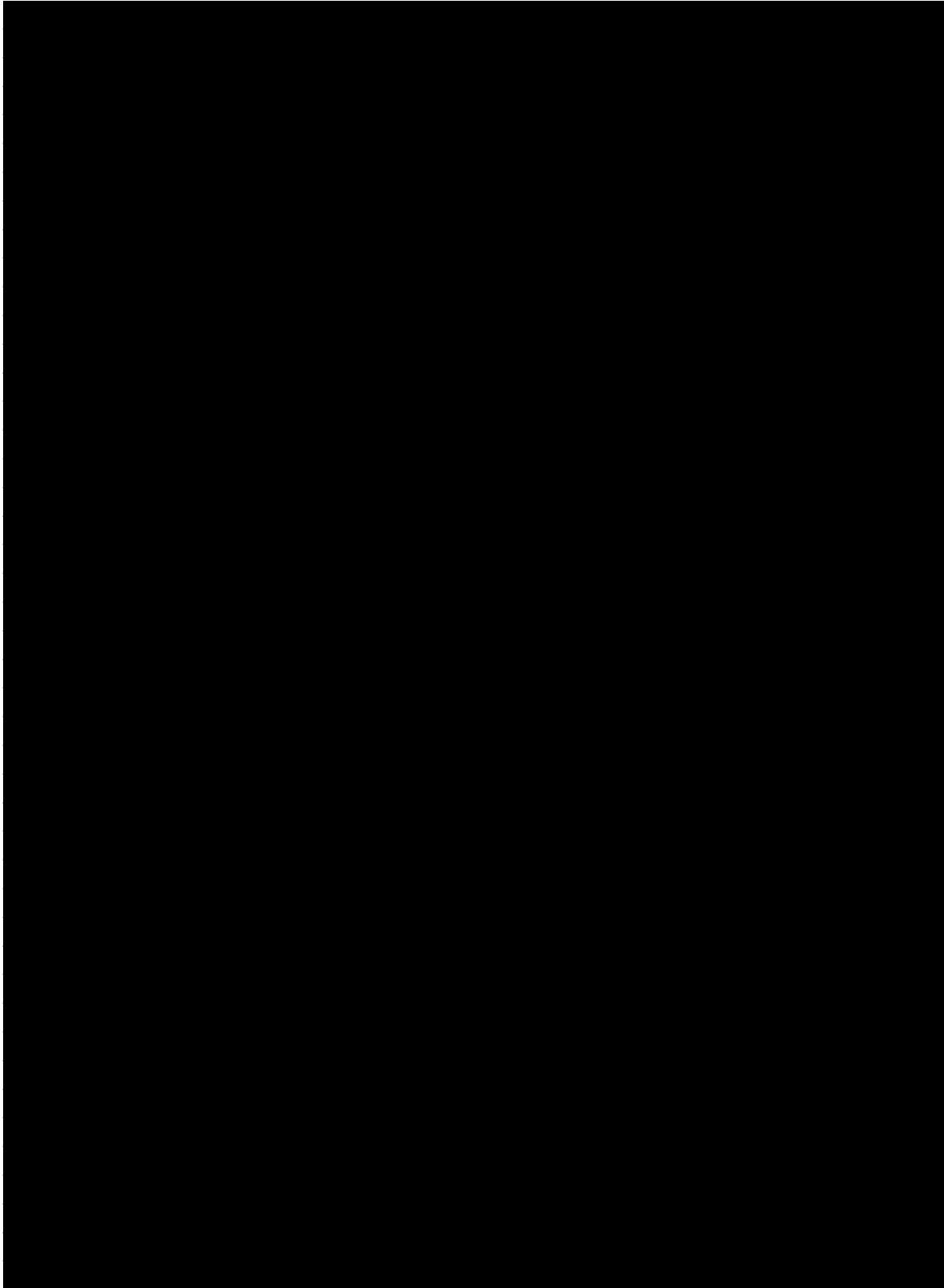
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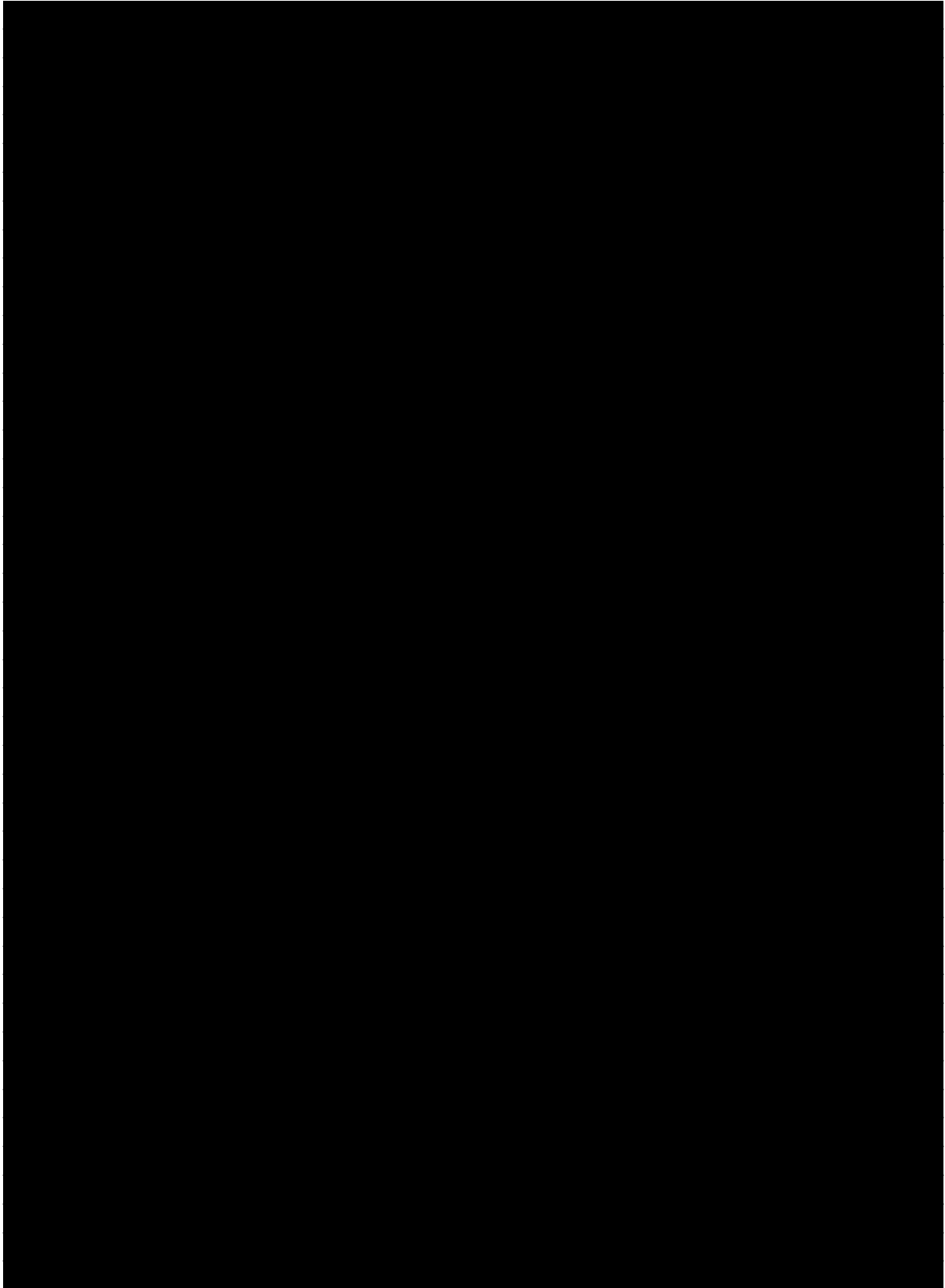


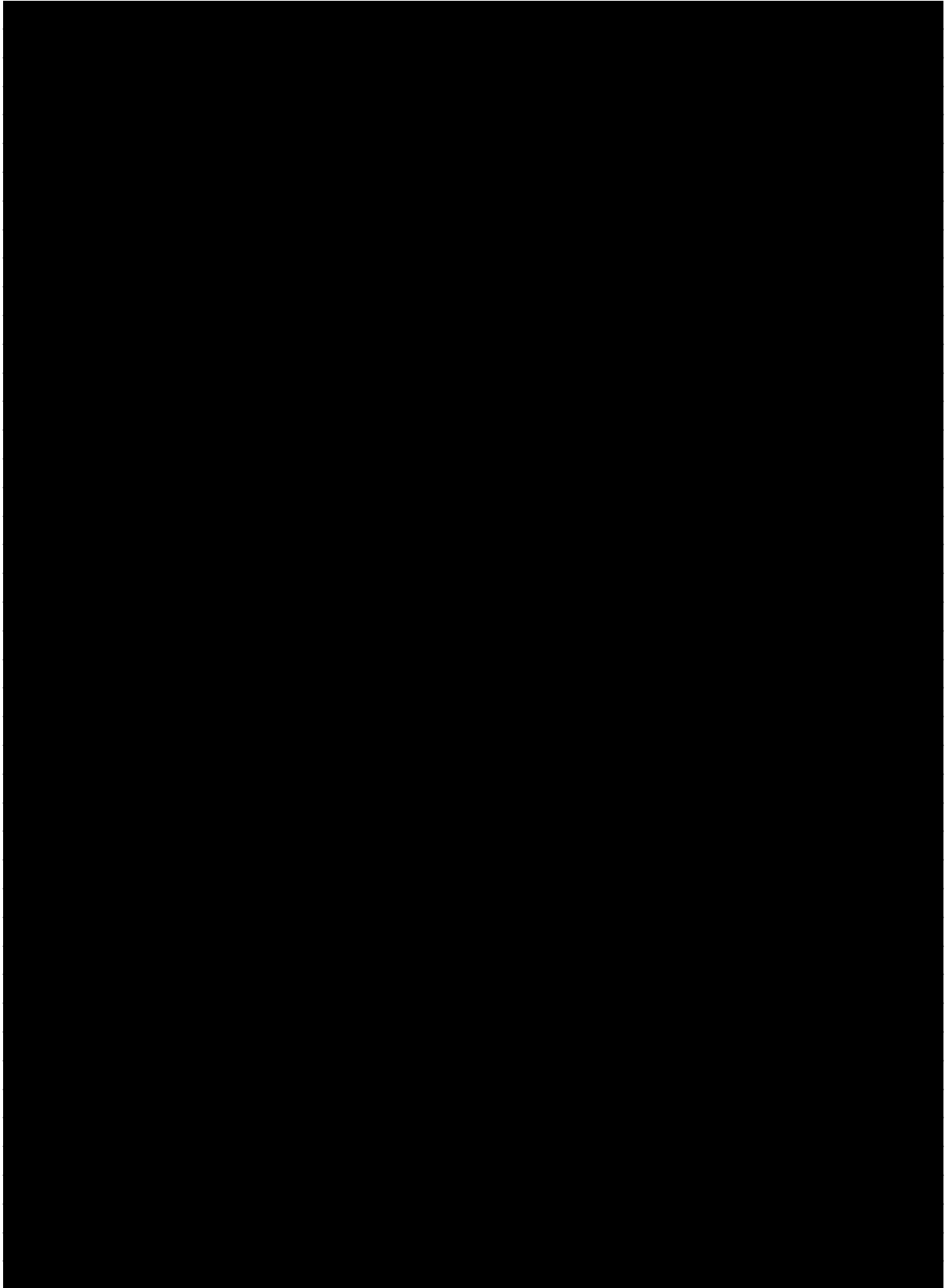






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Commissioner's Designee