STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: October 1, 2019
[redacted]
AGENCY: MAP
FH #: 8038190N

In the Matter of the Appeal of

[redacted]

from a determination by the New York City Department of Social Services

DECISION AFTER FAIR HEARING

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 December 4, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long-Term Care Plan (Centers Plan For Healthy Living)

Debra Ferguson, Fair Hearing Representative

ISSUE

Was the determination of the Appellant's Managed Long-Term Care Plan, Centers Plan For Healthy Living, to deny the Appellant's request for an increase in personal care services from 56 hours weekly to 24 hour live-in correct?

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 87, has been in receipt of a Personal Care Services Authorization in the amount of 8 hours/day, 7 days weekly through a Managed Long-Term Care Plan operated by Centers Plan For Healthy Living.

2. The Appellant made a request for the Appellant's personal care service hours to be increased from 56 hours weekly to 24 hour live-in.

3. By notice dated August 19, 2019, the Managed Long-Term Care Plan's determined to deny the Appellant's request for an increased Personal Care Services authorization from 56 hours per week to 24 hour live-in based on the NYS Department of Health Uniform Assessment System (UAS-NY).

4. The Appellant's Representative requested an appeal of the Long-Term Plan's determination to deny Appellant's request for an increased Personal Care Services authorization from 56 hours per week to 24-hour live in.

5. By notice dated August 21, 2019, the Managed Long-Term Care Plan's determined to deny the Appellant's appeal on the grounds that the service is not medically necessary.

6. On October 1, 2019, the Appellant requested this fair hearing.

APPLICABLE LAW

Section 505.14(a)(1) of the regulations defines "Personal Care Services" to mean assistance with nutritional and environmental support functions and personal care functions. Such services must be essential to the maintenance of the patient's health and safety in his or her own home….".

(2) **Continuous personal care services** means the provision of uninterrupted care, by more than one personal care aide, for more than 16 hours in a calendar day for a patient who, because of the patient's medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, or feeding and needs assistance with such frequency that a live-in 24-hour personal care aide would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

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

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(5) Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:

(i) Level I shall be limited to the performance of nutritional and environmental support functions.

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(b) The authorization for Level I services shall not exceed eight hours per week.

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(ii) Level II shall include the performance of nutritional and environmental support functions and personal care functions.

(a) Personal care functions include assistance with the following:

(1) bathing of the patient in the bed, the tub or in the shower;

(2) dressing;

(3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;

(4) toileting; this may include assisting the patient on and off the bedpan, commode or toilet;

(5) walking, beyond that provided by durable medical equipment, within the home and outside the home;

(6) transferring from bed to chair or wheelchair;

(7) turning and positioning

(8) preparing meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;

(9) feeding;

(10) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(11) providing routine skin care;

(12) using medical supplies and equipment such as walkers and wheelchairs; and

(13) changing of simple dressings.

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Section 505.14(b) of the Regulations provides that when a social services district receives a request for personal care services, it must determine whether the individual is eligible for Medical Assistance. The initial authorization for services shall be based on:

- a physician's order from the patient's physician based on the patient's current medical status as determined by a medical examination within 30 days of the request for Personal Care Services;

- a social assessment which must include a discussion with the patient to determine perception of his/her circumstances and preferences, an evaluation of the potential contribution of informal caregivers, such as family and friends, to the patient's care, and consideration of the number and kind of informal caregivers available to the patient, ability and motivation of informal caregivers to assist in care, extent of informal caregivers' potential involvement, availability of informal caregivers for future assistance, and acceptability to the patient of the informal caregivers' involvement in his/her care. The social assessment is completed by the Agency. When live-in 24-hour personal care services is indicated, the social assessment shall evaluate whether the patient's home has adequate sleeping accommodations for a personal care aide.

- a nursing assessment. The nursing assessment is completed by a nurse from a certified home health agency or by a nurse employed by the local social services department or by a nurse employed by a voluntary or proprietary agency under contract with the local social services department. The nursing assessment must be completed within 5 working days of the request and must include the following:

  (1) a review and interpretation of the physician's order;

  (2) the primary diagnosis code;

  (3) an evaluation of the functions and tasks required by the patient;

  (4) the degree of assistance required for each function and task;

  (5) an evaluation whether adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers and wheelchairs, can meet

the patient's need for assistance with personal care functions, and whether such equipment or supplies can be provided safely and cost-effectively.

(6) the development of a plan of care in collaboration with the patient or his/her representative; and

(7) recommendations for authorization of services.

- an assessment of the patient's appropriateness for hospice services and an assessment of the appropriateness and cost effectiveness of using adaptive or specialized medical equipment or supplies covered by the Medicaid Program including, but not limited to, bedside commodes, urinals, walkers, wheelchairs and insulin pens; and

Where there is a disagreement between the physician's order and the social, nursing and other required assessments, or there is a question about the level and amount of services to be provided, or if the case involves the provision of continuous Personal Care Services or live-in 24-hour personal care services as defined in paragraph (a)(2) and (a)(4), respectively, of this section, an independent medical review of the case must be completed by the local professional director, by a physician designated by the local professional director, or by a physician under contract with the Agency to review personal care services cases, who shall make the final determination about the level and amount of care to be provided.

Section 505.14(a)(3)(iii) of the regulations provides that Personal care services, including continuous personal care services and live-in 24-hour personal care services as defined in paragraphs (2) and (4), respectively, of this subdivision, shall not be authorized to the extent that the patient's need for assistance can be met by the following:

(1) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends, or other responsible adult;

(2) formal services provided or funded by an entity, agency or program other than the medical assistance program; or

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:

It is the Department's policy that 24-hour split-shift care should be authorized only when a person's nighttime needs cannot be met by a live-in aide or through either or both of the following: (1)adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, wheelchairs, and insulin pens, when the social services district determines that such equipment or supplies can be provided safely and cost-effectively; and (2)voluntary assistance available from informal caregivers or formal services provided by an entity or agency.

When a person's nighttime needs cannot be met by the use of adaptive or specialized equipment or supplies or voluntary assistance from informal caregivers or formal services, a determination must be made whether the person needs 24-hour split-shift care (included within the regulatory definition of "continuous personal care services") or live-in 24-hour personal care services. Under Section 505.14, this depends on whether the person needs "some" or "total" assistance with toileting, walking, transferring, or feeding, and whether these needs are "frequent" or "infrequent", and able to be "scheduled" or "predicted".

The intent of the regulation is to allow the identification of situations in which a person's needs can be met by a live-in aide and still allow the aide to have an uninterrupted five hours for sleeping. The Department is considering changes to the regulations to better achieve this goal.

In the meantime, the Department provides the following clarifications:

1. The fact that a person's needs are predictable does not preclude the receipt of 24-hour split-shift care, if the person has a documented medical need for the tasks to be performed with a frequency that would not allow a live-in aide to perform them and still obtain an uninterrupted five hours of sleep.

2. The need for turning and positioning and/or the need for diaper changes, by themselves, neither preclude nor justify the receipt of 24-hour split-shift care. In order to receive 24-hour split-shift care, the person must have a documented medical need for those tasks to be performed so frequently that a live-in aide cannot provide them and still obtain an uninterrupted five hours of sleep.

3. A person with a documented medical need for turning and positioning may, if otherwise appropriate, qualify for either 24-hour split-shift care or live-in care depending on the frequency at which turning and positioning is required at night, regardless of whether the person has a nighttime need for transferring.

4. When determining whether a person requires 24-hour split-shift care or live-in care, the local professional director must consider whether the physician's order and other required assessments document the following:

- The existence of a medical condition that directly causes the person to need frequent assistance with personal care services tasks during the night;
- The specific task or tasks with which the person requires frequent assistance during the night;
- The frequency at which the person requires assistance with these tasks during the night;
- Whether the person requires similar assistance with these tasks during the daylight hours and, if not, why not;

- The informal supports or formal services that are willing, able and available to provide assistance with the person's nighttime tasks;

- The person's ability to use adaptive or specialized equipment or supplies to meet his or her documented medical need for assistance with nighttime tasks; and whether the person's physician has documented that, due to the person's medical condition, he or she could not safely use the equipment or supplies; and

- Whether a live-in aide would likely be able to obtain an uninterrupted five hours of sleep were live-in services to be authorized.

Reauthorization for personal care services requires similar assessments as for the initial authorization; however, a nursing assessment is not required for Level I services if the physician's order indicates that the patient's medical condition is unchanged. Reauthorization of Level II services must include an evaluation of the services provided during the previous authorization period and must include a review of the nursing supervisory reports to assure that the patient's needs have been adequately met during the initial authorization period.

When there is a change in the patient's services needs which results solely from a change in his/her social circumstances, including, but not limited to, loss or withdrawal of support provided by informal caregivers, the social services department must review the social assessment, document the patient's social circumstances and make changes in the authorization as indicated. A new physician's order and nursing assessment is not required.

When there is a change in the patient's services needs which results from a change in his/her mental status including, but not limited to, loss of his/her ability to make judgments, the social services department must review the social assessment, document the changes in the patient's mental status and take appropriate action as indicated.

When there is a change in the patient's services needs which results from a change in his/her medical condition, the social services department must obtain a new physician's order and a new nursing assessment and shall complete a new social assessment. If the patient's medical condition continues to require the provision of personal care services, and the nursing assessment cannot be obtained within five working days of the request from the local social services department, the local department may make changes in the authorization in accordance with the procedures specified in 18 NYCRR 505.14(b)(5)(iv).

DISCUSSION

The credible evidence establishes that the Appellant has been in receipt of Personal Care Services provided through a Managed Long-Term Care Plan, operated by Centers Plan For Healthy Living. The evidence also establishes that by notice, dated August 19, 2019, the Managed Long-Term Care Plan determined to continue to authorize Personal Care Services authorization in the amount of 56 hours weekly.

At the hearing, the Appellant's Representative contended that the Appellant requires 24-hour live-in because the Appellant suffers from Alzheimer's, arthritis, diabetes, high blood pressure and he needs someone to watch him. The Appellant's Representative testified that the Appellant leaves the house. He testified that the hours are insufficient to assist the Appellant with his activities of daily living. When asked about the specific task-based assistance that the Appellant needs to justify the increase in the Appellant's Personal Care Services authorization, the Appellant's Representative contended that the Appellant needs assistance with tasks that include, but are not limited to toileting, toileting hygiene, medication reminder, meal preparation and indoor mobility.

The credible evidence establishes that on February 5, 2019 and August 9, 2019, a nursing assessor completed uniform assessment system evaluations of the Appellant's personal care needs. These uniform assessment system evaluations of the Appellant's personal care needs were carefully reviewed.

The August 9, 2019 assessment states total dependence-full performance by others during all episodes for: stairs, shopping, meal preparation and ordinary housework. It states extensive assistance-weight-bearing support (including lifting limbs) by 1+ helpers-or-weight-bearing support for more than 50% of subtasks for: transportation, bathing personal hygiene, dressing upper and lower body and toilet use. It states maximal assistance-help throughout task-performs less than 50% of task. With regard to walking and locomotion, the Uniform Assessment System evaluations of the Appellant's personal care needs establishes a need for limited assistance with walking, bed mobility, toilet transfer and locomotion in the form of guided maneuvering of limbs.

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.

The evidence has been considered. The credible evidence establishes that the Appellant requires appropriate monitoring and assistance with toileting and indoor mobility, to assure the

tasks are being safely completed. The Appellant's Representative's contention that the Appellant needs an increase in hours from 56 hours per week to 24 hour-live in because he needs to be watched is not a stand-alone task that may be authorized by Centers Plan. Based on the totality of the evidence, the Appellant's testimony fails to establish a change in his medical condition which warrants 24-hour live in. The credible evidence also establishes that the Appellant has a need for assistance with toileting and indoor mobility that is unscheduled and unpredictable. Thus, the credible evidence establishes that the Appellant is eligible for a "span of time" Personal Care Services authorization for "unscheduled needs" for toileting and indoor mobility assistance in order to bring the Appellant's Personal Care Services authorization up to 84 hours weekly (12 hours daily, 7 days weekly).

DECISION AND ORDER

Centers Plan For Healthy Living 's determination to deny an increase in Personal Care Services is not correct and is reversed.

1. The Centers Plan For Healthy Living is directed to authorize Personal Care Services to the Appellant in the amount of 12 hours per day, 7 days a week.

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

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

FH# 8038190N

DATED: Albany, New York
02/13/2020

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee