**STATE OF NEW YORK**
**DEPARTMENT OF HEALTH**

**REQUEST:** February 22, 2019
[redacted]
**AGENCY:** MAP
**FH #:** 7916094R

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 March 15, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Social Services Plan

Plan appearance waived by the Office of Administrative Hearings

## ISSUE

Was the Plan's determination to authorize Personal Care Services (PCW) for Appellant in the amount of 55 hours week 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 73, has been in receipt of a Personal Care Services Authorization in the amount of 46 hours through a program operated by Centers Plan for Healthy Living (herein referred to as the Plan).

2. On January 22, 2019, the Appellant's legal guardian requested an increase in the Appellant's PCW hours from 46 hours a week to 24 hours per week by a live-in aide because the health care service is not medically necessary.

3. On January 17, 2019, the Plan completed a Uniform Assessment System – Assessment (Comprehensive) (UAS) Report of the Appellant.

4. On January 17, 2019, the Nurse assessor completed a tasking tool which recommended 52.5 PCW hours per week.

5. By Notice of Initial Adverse determination dated January 28, 2019, the Plan notified the Appellant that the Appellant's request was partially denied.

6. The Notice further informed the Appellant that the Plan approved an increase to PCW of 55 hours per week.

7. On February 11, 2019, the legal guardian appealed the denial of January 28, 2019.

8. By Notice of final adverse determination dated February 13, 2019, the Plan decided not to change its decision to deny the request for an increase.

9. The Appellant seeks are view of the Plan's determination regarding the adequacy of the Appellant's Personal Care Services hours.

10. On February 22, 2019, the Appellant requested this fair hearing.

**APPLICABLE LAW**

Section 358-3.1 of the Regulations provides, in part:

(a) An applicant or recipient has the right to challenge certain determinations or actions of a social services Plan or such Plan's failure to act with reasonable promptness or within the time periods required by other provisions of this Title, by requesting that the Department provide a fair hearing. The right to request a fair hearing cannot be limited or interfered with in any way.

(b) If you are an applicant or a recipient of assistance, benefits or services you have a right to a fair hearing if:

(3) your public assistance, medical assistance, SNAP or services have been discontinued, suspended or reduced...

(6) your public assistance, medical assistance, HEAP or services are inadequate...

Part 438 of 42 Code of Federal Regulations (CFR) pertains to provision of Medicaid medical care, services and supplies through Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs) and Primary Care Case Managers (PCCMs), and the requirements for contracts for services so provided.

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

(a)Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.

(3) Provide that the MCO, PIHP, or PAHP--

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(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;

(iii) May place appropriate limits on a service

(A) Based on criteria applied under the State plan, such as medical necessity; or

(B) For utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes “medically necessary services”" in a manner that:

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

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

(A) The prevention, diagnosis, and treatment of health impairments.

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

(C) The ability to attain, maintain, or regain functional capacity.

(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require:

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP:

(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....

Section 438.236 of 42 CFR Subpart D provides, in pertinent part:

(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.

(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the field.

(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

(c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(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.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:
In the case of an MCO or PIHP- "Action" means--

(1) The denial or limited authorization of a requested service, including the type or level of service;
(2) The reduction, suspension, or termination of a previously authorized service;

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

Section 438.402 of 42 CFR Subpart F provides in part:

(a) The grievance system. Each MCO [Managed Care Organization] and PIHP [Prepaid Inpatient Health Plan] must have a system in place, for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system...

Section 438.406 of 42 CFR Subpart F provides in part:

(a) General requirements. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

(1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(2) Acknowledge receipt of each grievance and appeal.

(3) Ensure that the individuals who make decisions on grievances and appeals are individuals--

(i) Who were not involved in any previous level of review or decision-making; and

(ii) Who, if deciding any of the following, are health care professionals who have the

appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

(b) Special requirements for appeals. The process for appeals must:

(1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

(2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)

(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(4) Include, as parties to the appeal--
(i) The enrollee and his or her representative;

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.

OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

1. The Contractor agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42CFR 438.210; comply with professionally recognized standards of health care and implement practice guidelines consistent with 42CFR 438.236; and comply with the requirements of 438.114 regarding emergency and post-stabilization services to the extent that services required to treat an emergency medical condition are within the scope of covered services in Appendix G.

2. Benefit package services provided by the Contractor under this Contract shall comply with all standards of the State Medicaid Plan established pursuant to State Social Services Law Section 363-a and shall satisfy all applicable requirements of the State Public Health and Social Services

Law. Non-covered services for which the Enrollee is eligible under the Medicaid Program will be paid by the Department on a fee-for-service basis directly to the provider of service.

3. The Contractor agrees to allow each Enrollee the choice of Participating Provider of covered service to the extent possible and appropriate.

4. The Contractor agrees to maintain and demonstrate to the Department's satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through subcontracts. The Contractor shall meet the standards required by 42CFR 438.206 for availability of services; and 42CFR 438.207 for assurances of adequate capacity; and applicable sections of Public Health Law and regulations. If the network is unable to provide necessary services under this Contract for an Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractor's network for as long as the Contractor is unable to provide them within the network.

Appeal - a request for a review of an action taken by the Contractor.

Section B of Appendix K of the Managed Long-Term Care Contract, provides in part:

B. APPEALS

An Appeal is a request for a review of an action taken by a plan.

Expedited Appeal – the plan determines or the provider indicates that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function or the action was the result of a concurrent review of a service authorization request. A member may also request an expedited review of an appeal. If an expedited review is not requested, the appeal will be treated as a standard appeal.

Plans must designate one or more qualified personnel who were not involved in any previous level of review or decision-making to review the appeal, and if the appeal pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals. The plan may deny a request for an expedited review, but it must make reasonable efforts to give oral notice of denial of an expedited review and send written notice within 2 calendar days of oral request. The appeal is then handled as a standard appeal. A member's disagreement with plan's decision to handle as a standard appeal is considered a grievance – see Grievance Procedures.

An appeal may be filed orally or in writing. If oral, the plan must provide the member with a summary of the appeal in writing as part of acknowledgement or separately. The date of the oral request for both standard and expedited appeals is treated as the date of the appeal.
Note: New York has elected to require that a member exhaust the plan's internal appeal process before an enrollee may request a State Fair Hearing.

Section 2 of Appendix K of the Managed Long-Term Care Contract sets forth language relating to the managed long-term care demonstration grievance and appeal process which must appear in the Contractor's Member Handbook. This language includes:

*State Fair Hearings*

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 60 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you may also request to continue to receive these services while you are waiting for the Fair Hearing decision. You must check the box on the form you submit to request a Fair Hearing to indicate that you want the services at issue to continue. Your request to continue the services must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to reduce, suspend or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

18 NYCRR §. 505.10 Transportation for medical care and services. (a) Scope and purpose. This section describes the department's policy concerning payment for transportation services provided to Medical Assistance (MA) recipients, the standards to be used in determining when the MA program will pay for transportation, and the prior authorization process required for obtaining such payment. Generally, payment will be made only upon prior authorization for transportation services provided to an eligible MA recipient. Prior authorization will be granted by the prior authorization official only when payment for transportation expenses is essential for an eligible MA recipient to obtain necessary medical care and services which may be paid for under the MA program.

(b) Definitions.

(1) Ambulance means a motor vehicle, aircraft, boat or other form of transportation designed and equipped to provide emergency medical services during transit.

(2) Ambulance service means any entity, as defined in section 3001 of the Public Health Law, which is engaged in the provision of emergency medical services and the transportation of sick, disabled or injured persons by motor vehicle, aircraft, boat or other form of transportation to or from facilities providing hospital services and which is currently certified or registered by the Department of Health as an ambulance service.

(3) Ambulette or invalid coach means a special-purpose vehicle, designed and equipped to provide nonemergency transport, that has wheelchair-carrying capacity, stretcher-carrying capacity, or the ability to carry disabled individuals.

(4) Ambulette service means an individual, partnership, association, corporation, or any other legal entity which transports the invalid, infirm or disabled by ambulette to or from facilities which provide medical care. An ambulette service provides the invalid, infirm or disabled with personal assistance as defined in this subdivision.

(5) Common medical marketing area means the geographic area from which a community customarily obtains its medical care and services.

(6) Community means either the State, a portion of the State, a city or a classification of the population, such as all persons 65 years of age and older.

(7) Conditional liability means that the prior authorization official is responsible for making payment only for transportation services which are provided to MA-eligible individuals in accordance with the requirements of this Title.

(8) Day treatment program or continuing treatment program means a planned combination of diagnostic, treatment and rehabilitative services certified by the Office of Mental Retardation and Developmental Disabilities or the Office of Mental Health.

(9) Department established rate means the rate for any given mode of transportation which the department has determined will ensure the efficient provision of appropriate transportation to MA recipients for the recipients to obtain necessary medical care or services.

(10) Emergency ambulance transportation means the provision of ambulance transportation for obtaining hospital services for an MA recipient who suffers from severe, life-threatening or potentially disabling conditions which require the provision of emergency medical services while the recipient is being transported.

(11) Emergency medical services means the provision of initial urgent medical care including, but not limited to, the treatment of trauma, burns, and respiratory, circulatory and obstetrical emergencies.

(12) Locally prevailing rate means a rate for a given mode of transportation which is established by a transit or transportation authority or commission empowered to establish rates for public transportation, a municipality, or a third-party payor, and which is charged to all persons using that mode of transportation in each community.

(13) Locally established rate means the rate for any given mode of transportation which the social services official has determined will ensure the efficient provision of appropriate transportation for MA recipients for the recipients to obtain necessary medical care or services.

(14) Nonemergency ambulance transportation means the provision of ambulance transportation for obtaining necessary medical care or services to an MA recipient whose medical condition requires transportation by an ambulance service.

(15) Ordering practitioner means the MA recipient's attending physician or other medical practitioner who has not been excluded from enrollment in the MA program and who is requesting transportation on behalf of the MA recipient in order that the MA recipient may obtain medical care or services which are covered under the MA program. The ordering practitioner is responsible for initially determining when a specific mode of transportation to a medical care or service is medically necessary.

(16) Personal assistance means the provision of physical assistance by a provider of ambulette services or the provider's employee to an MA recipient for assuring safe access to and from the recipient's place of residence, ambulette vehicle and MA covered health service provider's place of business. Personal assistance is the rendering of physical assistance to the recipient in walking, climbing or descending stairs, ramps, curbs or other obstacles; opening or closing doors; accessing an ambulette vehicle; and the moving of wheelchairs or other items of medical equipment and the removal of obstacles as necessary to assure the safe movement of the recipient. In providing personal assistance, the provider or the provider's employee will physically assist the recipient which shall include touching, or, if the recipient prefers not to be touched, guiding the recipient in such proximity that the provider of services will be able to prevent any potential injury due to a sudden loss of steadiness or balance. A recipient who can walk to and from a vehicle, his or her home, and a place of medical services without such assistance is deemed not to require personal assistance.

(17) Prior authorization means a prior authorization official's determination that payment for a specific mode of transportation is essential for an MA recipient to obtain necessary medical care and services and that the prior authorization official accepts conditional liability for payment of the recipient's transportation costs.

(18) Prior authorization official means the department, a social services district, or their designated agents.

(19) Transportation attendant means any individual authorized by the prior authorization official to assist the MA recipient in receiving safe transportation.

(20) Transportation expenses means:

(i) the costs of transportation services; and

(ii) the costs of outside meals and lodging incurred when going to and returning from a provider of medical care and services when distance and travel time require these costs.

(21)Transportation services means:

(i) transportation by ambulance, ambulette or invalid coach, taxicab, common carrier or other means appropriate to the recipient's medical condition; and

(ii) a transportation attendant to accompany the MA recipient, if necessary. Such services may include the transportation attendant's transportation, meals, lodging and salary; however, no salary will be paid to a transportation attendant who is a member of the MA recipient's family.

(22)Undue financial hardship means transportation expenses which the MA recipient cannot be expected to meet from monthly income or from available resources. Such transportation expenses may include those of a recurring nature or major one-time costs.

(23) Vendor means a lawfully authorized provider of transportation services who is either enrolled in the MA program pursuant to Part 504 of this Title or authorized to receive payment for transportation services directly from a social services district or other agent designated by the department. The term vendor does not mean an MA recipient or other individual who transports an MA recipient by means of a private vehicle.

(c) Ambulette and nonemergency ambulance transportation. (1) Who may order. Only those practitioners, facilities or programs listed in paragraph (d)(4) of this section may order or submit an order on behalf of a practitioner for ambulette or nonemergency ambulance transportation services.

(2) Criteria for ordering ambulette transportation. Ambulette transportation may be ordered if any one of the following conditions exist:

(i) The recipient needs to be transported in a recumbent position and the ambulette service ordered has stretcher-carrying capacity;

(ii) The recipient is wheelchair bound and is unable to use a taxi, livery service, bus or private vehicle;

(iii) The recipient has a disabling physical condition which requires the use of a walker or crutches and is unable to use a taxi, livery service, bus or private vehicle;

(iv) The recipient has a disabling physical condition other than one described in subparagraph (iii) of this paragraph or a disabling mental condition, either of which requires the personal assistance provided by an ambulette service, and the ordering practitioner certifies, in a manner designated by the department, that the recipient cannot be transported by a taxi, livery service, bus or private vehicle and requires transportation by ambulette service; or

(v) An otherwise ambulatory recipient requires radiation therapy, chemotherapy, or dialysis treatment which results in a disabling physical condition after treatment and renders the recipient unable to access transportation without the personal assistance provided by an ambulette service.

18 NYCRR § 505.14(a)(1) provides that Personal care services means assistance with nutritional and environmental support functions and personal care functions, as specified in 18 NYCRR §§ 505.14(a)(5)(i)(a) and 505.14(a)(5)(ii)(a). Such services must be essential to the maintenance of the patient's health and safety in his or her own home, as determined by the social services district in accordance with Section 505.14; ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services specified in 18 NYCRR § 505.14(b)(3)(iv); provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

18 NYCRR § 505.14(a)(2) provides that 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.

18 NYCRR § 505.14(a)(3)(iii) provides that Personal care services, including continuous personal care services and live-in 24-hour personal care services, 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, Plan or program other than the medical assistance program; or

(3) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively.

18 NYCRR § 505.14(a)(3)(iii) provides that the social services district must first determine whether the patient, because of the patient's medical condition, would be otherwise eligible for personal care services, including continuous personal care services or live-in 24-hour personal care services. For patients who would be otherwise eligible for personal care services, the district must then determine whether, and the extent to which, the patient's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies.

18 NYCRR § 505.14(a)(4) provides that 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.

Section 505.14(a)(4)(iii) of the regulations provides personal care services shall not be authorized if the patient's need for assistance can be met by either or both of the following:

(a) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends or other responsible adult; or formal services provided by an entity or Plan; or

(b) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively.

Regulations at 18 NYCRR §§ 505.14(a)(5)(ii)(b), 505.14(b)(4)(i)(c)(2) provides that the nursing assessment in continuous (split-shift) and live-in cases shall document the following:

(i) whether the physician's order has documented a medical condition that causes the patient to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding;

(ii) the specific personal care functions with which the patient needs frequent assistance during a calendar day;

(iii) the frequency at which the patient needs assistance with these personal care functions during a calendar day;

(iv) whether the patient needs similar assistance with these personal care functions during the patient's waking and sleeping hours and, if not, why not; and

(v) whether, were live-in 24-hour personal care services to be authorized, the 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.

Regulations at 18 NYCRR § 505.14(b)(5)(v)(c)(1) provide that appropriate reasons and notice language to be used when denying personal care services include but are not limited to the following:

(v) the client refused to cooperate in the required assessment;

Regulations at 18 NYCRR § 505.14(b)(5)(v)(d) provides that the social services district may not authorize or reauthorize personal care services based upon a task-based assessment when the applicant or recipient of personal care services has been determined by the social services district or the State to need 24-hour personal care, including continuous personal care services, live-in 24-hour personal care services or the equivalent provided by formal services or informal caregivers.

**DISCUSSION**

The uncontroverted evidence establishes that the Appellant, age 73, has been in receipt of a Personal Care Services Authorization in the amount of 46 hours through a program operated by Centers Plan for Healthy Living (herein referred to as the Plan). On January 22, 2019, the Appellant's legal guardian requested an increase in the Appellant's PCW hours from 46 hours a week to 24 hours per week by a live-in aide because the health care service is not medically necessary. On January 17, 2019, the Plan completed a Uniform Assessment System – Assessment (Comprehensive) (UAS) Report of the Appellant. On January 17, 2019, the Nurse assessor completed a tasking tool which recommended 52.5 PCW hours per week. By Notice of Initial Adverse determination dated January 28, 2019, the Plan notified the Appellant that the Appellant's request was partially denied. The Notice further informed the Appellant that the Plan approved an increase to PCW of 55 hours per week.

On February 11, 2019, the legal guardian appealed the denial of January 28, 2019. By Notice of final adverse determination dated February 13, 2019, the Plan decided not to change its decision to deny the request for an increase. The Appellant seeks are view of the Plan's determination regarding the adequacy of the Appellant's Personal Care Services hours.

A review of the record establishes that the Appellant suffers from Parkinson's, flex deformity of fingers and other comorbidities. According to the UAS, the Appellant's health conditions cause pain and debility, decreased range of movement and unsteady gait. The Appellant requires significant assistance with ambulating, dressing, eating, bathing and taking care of personal hygiene. The Appellant uses a wheel chair for locomotion and has to be wheeled by others.

The Appellant's representative contended that the provided hours are inadequate to meet the Appellant's activity of daily living (ADL) with respect to personal hygiene and locomotion. The representative argued that the Appellant is incontinent of bowel and bladder and needs the extra hours to assist the Appellant with, ambulation, diaper changing and cleaning up after toilet use. The Appellant cannot perform any of these activities due to the deformity of the fingers and he an inability to push the wheelchair himself. The Appellant resides with his wife who works outside of the home from 7:00am to 6:00pm. The personal aide currently works from 7:30am to 3:00pm. The Appellant therefore does not have aide services to assist with toileting and hygiene for three or more hours until his wife gets home. The representative argued that the Appellant would benefit from increased home care assistance hours because the Appellant needs help after the aide leaves for the day.

At a hearing concerning the adequacy of services, the Appellant must establish that the Plan erred in its determination. The Appellant's representative's testimony has been considered, but it was found not persuasive to establish that the demands of the Appellant's medical condition require that the Appellant should be provided with 24 hours of PCW service by a live-in aide. The record however establishes that the Appellant's needs can be sufficiently and safely met by PCW of 84 hours per week (12 hours per day, 7 days per week).

**DECISION AND ORDER**

The Plan's determination to authorize Personal Care Services for Appellant in the amount of 55 hours week is not correct and is reversed.

1. The Plan is directed to authorize Personal Care Services to the Appellant in the amount of 84 hours per week.

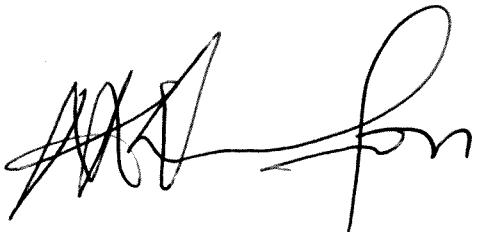
Should the Plan need additional information from the Appellant to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Plan promptly to facilitate such compliance.

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

DATED: Albany, New York
03/27/2019

NEW YORK STATE OFFICE OF
TEMPORARY AND DISABILITY ASSISTANCE

By



Commissioner's Designee