STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: February 25, 2019
[redacted]
AGENCY: MAP
FH #: 7917761M

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 22, 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 Agency

Deborah Ferguson, Fair Hearing Representative

ISSUE

Was the Medicaid Managed Long Term Care Plan's determination to deny the Appellant's request for 24 hours, continuous ("split-shift") Personal Care Services (168 hours per 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 79, has been in receipt of Medicaid benefits provided through a Medicaid Managed Long Term Care Plan, Centers Plan for Healthy Living (hereinafter "Plan").

2. From October 1, 2018 to January 31, 2019, the Appellant was approved for 11 hours/day X 7 days a week of Personal Care Services.

3. On December 4, 2018, the Appellant requested approval for 12 hours day X 2 split shift aides per day for 7 days a week.

4. By Initial Adverse Determination Notice dated December 19, 2018, the Agency determined to deny the Appellant's request for 12 hours a day X 2 split shift aides per day for 7 days a week.

5. Pursuant to the Appellant's internal plan appeal, the Agency issued a Final Adverse Determination Notice date January 4, 2019, "the plan approval **stays** at: Personal Aide Level 2:11 hours per day – 7 days per week – a total of 77 hours per week from December 20, 2018 to May 31, 2019". The Plan explained, "your abilities to perform physical functioning stayed the same for dressing upper and lower body, personal hygiene (cleaning yourself), walking, transfer toilet (getting on and off the toilet), eating, bed mobility (moving around the bed), meal preparation, and ordinary housework.

6. On November 29, 2018, a follow-up face-to-face clinical assessment was performed utilizing the New York State Department of Health's Uniform Assessment System Tool that showed most of your abilities to perform physical functioning stayed the same since your prior assessment that was completed by Centers Plan for Healthy Living on July 31, 2018.

7. On February 25, 2019, the Appellant requested this fair hearing.

APPLICABLE LAW

Regulations at 18 NYCRR 358-5.9 provides that, at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance benefits and Services, the Appellant must establish that the Agency's denial of assistance or benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits.

Section 358-2.21 states that a "social services agency" means the State, county, city, town official or town agency, social services district or HEAP certifying agency responsible for making the determination or for the failure to act, which is the subject of review at the fair hearing.

Section 358-3.3(a)(1) states, in relevant part, a recipient has a right to a timely and adequate notice when a social services agency proposes to take any action to discontinue, suspend, or reduce a Medical Assistance Authorization or services. A timely notice means a notice which is mailed at least 10 days before the date upon which the proposed action is to become effective. 18 NYCRR 358-2.23.

Section 505.14(a)(2) of the Regulations 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.

Section 505.14(a)(4) of the Regulations 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)(5) of the Regulations provides, in pertinent part, that personal care services shall include the following two levels of care, and be provided in accordance with the following standards:

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

(a) Nutritional and environmental support functions include assistance with the following:

(1) making and changing beds;
(2) dusting and vacuuming the rooms which the patient uses;
(3) light cleaning of the kitchen, bedroom and bathroom;
(4) dishwashing;
(5) listing needed supplies;
(6) shopping for the patient if no other arrangements are possible;
(7) patient's laundering, including necessary ironing and mending;
(8) payment of bills and other essential errands; and
(9) preparing meals, including simple modified diets.

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

(ii) Level II shall include the performance of nutritional and environmental support functions specified in clause (i)(*a*) of this paragraph 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 of 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.

(b) Before continuous personal care services or live-in 24-hour personal care services may be authorized, additional requirements for the authorization of such services, as specified in clause (b)(4)(i)(*c*) of this section, must be met.

Section 505.14(a) of the Regulations states that Personal Care Services shall not be provided to patients whose condition requires frequent nursing judgment or monitoring of an unstable medical situation.

Section 505.14(a)(4), personal care services, as defined in this section: Personal care services can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with the regulations of the Department of Health.

(i) The patient's medical condition shall be stable, which shall be defined as follows:
(a) the condition is not expected to exhibit sudden deterioration or improvement; and
(b) the condition does not require frequent medical or nursing judgment to determine changes in the patient's plan of care; and
(c) (1) the condition is such that a physically disabled individual is in need of routine supportive assistance and does not need skilled professional care in the home; or
(2) the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing.

(ii) The patient shall be self-directing, which shall mean that he/she is capable of making choices about his/her activities of daily living, understanding the impact of the choice and assuming responsibility for the results of the choice. Patients who are non-self-directing, and who require continuous supervision and direction for making choices about activities of daily living shall not receive personal care services, except under the following conditions:
(a) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual living within the same household; or
(b) supervision or direction is provided on an interim or part-time basis as part of a plan

of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual not living within the same household; or
(c) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by an outside agency or other formal organization. The local social services department may be the outside agency.

Administrative Directive 92 ADM-49 provides in pertinent part:

B. Health and Safety of Recipient

Personal care services may only be authorized when the district reasonably expects that the recipient's health and safety can be maintained in the home. This determination must consider the following:

1. Stability of the Recipient's Medical Condition

The assessing nurse has primary responsibility for determining stability of the recipient's medical condition. The recipient and/or any informal caregiver should be given the opportunity to be involved in this determination. The determination should be based on information included in the nursing assessment and a review of the physician's order. In situations where there is a question about this determination, the assessing nurse may wish to involve the case manager or obtain consultation from the local professional director or his/her designee.

A stable medical condition is defined as follows:

a. the condition is not expected to exhibit sudden deterioration or improvement; and
b. the condition does not require frequent medical or nursing judgment to determine changes in the recipient's plan of care; and
c. the condition is such that a physically disabled individual is in need of routine supportive assistance to maintain his or her level of functioning and does not need skilled professional care in the home; or
d. the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing.

If the recipient's medical condition is not stable, the provision of personal care services is inappropriate unless a determination is made that the provision of personal care services in combination with the intervention of appropriate skilled nursing services, home health aide and/or therapy can adequately meet the recipient's needs.

2. Ability of the Recipient to be Self-Directing

The case manager has primary responsibility for determining the recipient's self-directing capability. The determination should be based on a review of available information in the physician's order and the social and nursing assessments. The case manager must be sensitive to

the recipient's habits, factors in the recipient's physical environment and relationships with informal caregivers that might impede the recipient's ability to consistently be self-directing. In situations where there is a question about the final determination, the case manager should consult with the assessing nurse, the local professional director or his/her designee or protective services for adult's case managers. The case manager may also wish to obtain a psychiatric evaluation.

Self-directing means that the recipient has the capability to make choices about activities of daily living, understand the impact of these choices and assume responsibility for the results of these choices...

A non-self-directing recipient lacks the capability to make choices about the activities of daily living, understand the implications of these choices, and assume responsibility for the results of these choices. Characteristics of a non-self-directing recipient include:

a. the recipient may be delusional, disoriented at times, have periods of agitation, or demonstrate other behavior which is inconsistent and unpredictable; or
b. the recipient may have a tendency to wander during the day or night and to endanger his or her physical safety through exposure to hot water, extreme cold, or misuse of equipment or appliances in the home; or
c. the recipient may exhibit other behaviors which are harmful to himself or herself or to others such as hiding medications, taking medications without his or her physician's knowledge, refusing to seek assistance in a medical emergency, or leaving lit cigarettes unattended. The recipient may not understand what to do in an emergency situation or know how to summon emergency assistance.

Personal care services may only be provided to non-self-directing recipients if the responsibility for direction is assumed by another individual or an outside agency and any needed supervision or direction is provided on a part-time or interim basis by that individual or agency....

Responsibility for part-time or interim supervision may be assumed by:
- o a self-directing individual who resides in the recipient's household; or
- o a legally or non-legally responsible relative, friend, neighbor, or other informal caregiver who is self-directing; or
- o a formal agency such as an area office for the aging; or
- o a self-directing individual who lives in another household.

If the individual assuming part-time or interim supervision resides outside of the recipient's home, consideration should be made as to whether that individual has substantial daily contact with the recipient in the recipient's home.

Factors used to determine whether substantial daily contact in the recipient's home is being made include:
- o the individual is physically present in the home at times throughout the day or

night as necessary to assure the safety of the recipient; and

- o any discretionary decisions or choices involved in carrying out the functions and tasks identified in the recipient's plan of care are conveyed to the person providing personal care services.

Substantial daily contact does not mean the individual must be physically present in the home for a specified amount of time. The frequency of contact needed to assure a safe situation and provide discretionary direction should be based on each recipient's case situation as reflected in the social and nursing assessments and in the recipient's plan of care.

Supervision and direction of non-self-directing recipients is not an appropriate role for individuals providing personal care services. Such individuals can perform the functions or tasks specified in the recipient's plan of care as instructed by another person. They can also observe and monitor the recipient for possible changes in his/her functioning. However, when changes are noted, the individual is responsible for reporting his/her observations to the appropriate professional for review and decisions about the recipient's plan of care.

If the recipient has no individual or outside formal agency willing to assume responsibility for his/her supervision and direction, a referral should be made to the protective services for adult's program for a protective services assessment. Denial or termination of personal care services may be required if the recipient's health and safety cannot be assured by involvement of other individuals, outside formal agencies or the protective services for adults (PSA) program....

Regulation 505.14(b)(3)(iv) (a) (1) provides, in pertinent part, that before authorizing or reauthorizing personal care services, a social services district must assess each patient to determine whether personal care services can be provided according to the patent's plan of care, whether such services are medically necessary and whether the social services district reasonably expects that such services can maintain the patient's health and safety in his or her home, as determined in accordance with the regulations of the Department of Health.

Section 505.23(a) provides in relevant part as follows:

(3) Home health services mean the following services when prescribed by a physician and provided to an MA recipient in his or her home other than a general hospital or an RHCF:
(i) nursing services provided on a part-time or intermittent basis by a certified home health agency or, if no certified home health agency is available, by a registered professional nurse or a licensed practical nurse acting under the direction of a recipient's physician;
(ii) physical therapy, occupational therapy, or speech pathology and audiology services; and
(iii) home health aide services, as defined in the regulations of the Department of Health, provided by a person who meets the training requirements of the Department of Health, is assigned by a registered professional nurse to provide home health aide services in accordance with a recipient's plan of care, and is supervised by a

registered professional nurse from a certified home health agency or a therapist, in accordance with the regulations of the Department of Health.

Section 505.23(b) provides in relevant part as follows:

(1) A certified home health agency must provide home health services in accordance with applicable provisions of the regulations of the Department of Health (Article 7 of Subchapter C of Chapter V of Title 10 NYCRR) and with federal regulations governing home health services (42 C.F.R. 440.70 and Part 484). (42 CFR Part 430 to end, revised annually as of October 1, is published by the Office of the Federal Register, National Archives and Records Administration, and is available for public use and inspection at the Department of Social Services, 40 North Pearl St., Albany, New York 12243.)

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 438.236 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 particular 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.

With respect to notice requirements, Section 438.210 of 42 CFR Subpart D provides, in pertinent part:

(c) Notice of adverse action. Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs and PIHPs, the notice must meet the requirements of Sec. 438.404, except that the notice to the provider need not be in writing.

(d) Timeframe for decisions. Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices:

(1) Standard authorization decisions. For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service…

Section 438.404(b) of 42 CFR Subpart F provides in part:

(b) Content of notice. The notice must explain the following:
(1) The action the MCO or PIHP or its contractor has taken or intends to take;
(2) The reasons for the action...

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) On the basis of criteria applied under the State plan, such as medical necessity; or
(B) For the purpose of 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....

Private Duty Nursing

Section 505.8 of the Regulations provides, in pertinent part:

(a) Where nursing care may be provided. Nursing service as medically needed shall be provided to medical assistance recipients in the person's home or in a hospital.

(b) Who may provide nursing care.
(1) Nursing care to patients in New York State shall be provided by a person possessing a license and current registration from the New York State Education Department to practice as a registered professional nurse or licensed practical nurse.

(d) Nursing service in the home.
(1) For necessary nursing service to be provided in the person's home, full and primary use shall be made of the services of an approved home health agency, including a hospital-based home health agency.
(2) Such service shall be provided on a per visit basis and may include not only intermittent or part-time nursing service for the patient but also instructions to members of the patient's family in procedures necessary for the care of the patient.
(3) **Service of a registered professional nurse or of a licensed practical nurse on a private practitioner basis may be provided to a patient in his own home only under the following circumstances**:
(i) when there is no approved home health agency available to provide the intermittent or part-time nursing services needed by the patient;
(ii) when the patient is in need of individual and continuous nursing care beyond that available from an approved home health agency.

(e) Prior approval and prior authorization. Prior approval by the local professional director and prior authorization by the local social services official shall be required for nursing service provided in a person's home or in a hospital by a private practicing

registered professional or licensed practical nurse, except that in an urgent situation the attending physician may order the service of such nurse for no more than two nursing days and immediately notify the local social services official and the appropriate medical director.

(f) **Physician's written order required**. All nursing services provided in the patient's home or in a hospital shall be in accordance with the attending physician's written order and plan of treatment, however, in extraordinary circumstances and for valid reasons which must be documented, nursing service in the home may be initiated by a home health agency before the physician sees the patient. A physician's written order is required for all such nursing services in excess of the initial two visits.

The Private Duty Nursing Manual Policy Guidelines states, in relevant part, all private duty nursing shall be in accordance with the attending physician's written order and treatment plan. It further states that approval for private duty nursing services shall be at the licensed practical nursing level unless:

(a) The physician's order specifically justifies in writing the reasons why registered nurse (RN) nurse services are necessary. In this case, the Medicaid Director or local designee must be in agreement.
(b) The required skills are outside the scope of practice for a licensed practical nurse (LPN) as determined by the NYSED.

Section 6902 of Article 139 of the Education Law distinguishes between the legal definitions of RNs and LPNs as follows:

The practice of the profession of nursing as a registered professional nurse (RN) is defined as diagnosing and treating human responses to actual or potential health problems through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens prescribed by a licensed physician, dentist or other licensed health care provider legally authorized under this title and in accordance with the commissioner's regulations. A nursing regimen shall be consistent with and shall not vary any existing medical regimen.

The practice of nursing as a licensed practical nurse (LPN) is defined as performing tasks and responsibilities within the framework of case finding, health teaching, health counseling, and provision of supportive and restorative care under the direction of a registered professional nurse or licensed physician, dentist or other licensed health care provider legally authorized under this title and in accordance with the commissioner's regulations.

Furthermore, section 6901 of Article 139 of the Education Law provides the following definitions relating to the scope of practice of RNs:

1. "Diagnosing" in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis.
2. "Treating" means selection and performance of those therapeutic measures essential to the effective execution and management of the nursing regimen, and execution of any prescribed medical regimen.
3. "Human Responses" means those signs, symptoms and processes which denote the individual's interaction with an actual or potential health problem.

Section 6902, cited above, does not include nursing diagnosis within the scope of practice of LPNs.

The New York State Education Department's Practice Information provides guidelines as to the scope of practice between RNs and LPNs. Said guidelines states that RNs executes medical orders from select authorized health care providers, function independently in providing nursing care in such areas as the ongoing surveillance and nursing intervention to rescue chronically ill persons from development of negative effects and secondary results of treatments.

It further provides that nursing diagnosis is interpreted as including patient assessment, that is, the collection and interpretation of patient clinical data, the development of nursing care goals and the subsequent establishment of a nursing care plan. Additionally, LPNs do not have assessment privileges; they may not interpret patient clinical data or act independently on such data; they may not triage; they may not create, initiate, or alter nursing care goals or establish nursing care plans. Under the direction of the RN, LPNs may administer medications, provide nursing treatments, and gather patient measurements, signs, and symptoms that can be used by the RN in making decisions about the nursing care of specific patients. However, they may not function independent of direction.

Section 364.2 of the Regulations provides in part, as follows:

The Department of Health shall be responsible for . . .

(b) establishing and maintaining standards for all non-institutional health care and services rendered pursuant to this title, . . .

Section 505.8 of the Regulations, which governs the provision of nursing services, provides:

(a) Where nursing care may be provided:

Nursing services, as medically needed, may be provided to a medical assistance recipient in the person's home or in a hospital and, with respect to a child receiving nursing services pursuant to an individualized education program or an interim or final individualized family

services plan, also in a school, an approved pre-school or a natural environment, including home and community settings, where such child would otherwise be found.

(b) Who may provide nursing care:

(1) Nursing care to patients in New York State shall be provided by a person possessing a license and current registration from the New York State Education Department to practice as a registered professional nurse or licensed practical nurse.

(2) Out-of-state nurses providing care to a New York State Medical Assistance patient who is temporarily located outside New York State, must be licensed and registered in the state in which they are practicing.

(c) Private duty nursing care in the hospital:

Private duty nursing care in the hospital shall be provided on the recommendation of the patient's attending physician when the patient is in need of individual and continuous care beyond that available by the staff of a hospital, including that which is available in a critical care area.

(d) Nursing service in the home:

(1) For necessary nursing service to be provided in the person's home, full and primary use shall be made of the services of an approved home health agency, including a hospital based home health agency.

(2) Such service shall be provided on a per visit basis and may include not only intermittent or part-time nursing service for the patient but also instructions to members of the patient's family in procedures necessary for the care of the patient.

(3) Service of a registered professional nurse or of a licensed practical nurse on a private practitioner basis may be provided to a patient in his own home only under the following circumstances:

(i) when there is no approved home health agency available to provide the intermittent or part-time nursing services needed by the patient;

(ii) when the patient is in need of individual and continuous nursing care beyond that available from an approved home health agency.

(e) Prior approval and prior authorization:

Prior approval by the local professional director and prior authorization by the local social services official shall be required for nursing service provided in a person's home or in a hospital by a private practicing registered professional or licensed practical nurse, except that in an urgent situation the attending physician may order the service of such nurse for no more than two

nursing days and immediately notify the local social services official and the appropriate medical director.

(f) Physician's written order required:

All nursing services provided by a registered professional nurse or licensed professional nurse in a recipient's home, a hospital, a school, an approved pre-school, or a natural environment, including home and community settings, where such child would otherwise be found, must be provided in accordance with the attending physician's written order and plan of treatment. In extraordinary circumstances and for valid reasons which must be documented, nursing services in the home may be initiated by a home health agency before the physician examines the recipient. A physician's written order is required for all such nursing services in excess of the initial two visits.

MLTC Policy 13.07: dated March 13, 2013, is being provided as background on Fee-For-Service Medicaid private duty nursing services prior to initiation of transitioning cases in Mandatory Managed Long-Term Care counties. NYCRR Title 10 and Title 18 contain regulations for the provision of Medicaid coverage of private duty nursing services in the patient's home or in a school.

Private duty nursing services may be provided when a written assessment from a Certified Home Health Agency, local Social Services department or recognized agent of a local Social Services department indicates that the patient is in need of either continuous nursing services which are beyond the scope of care available from a certified home health agency, or intermittent nursing services which are normally provided by the certified home health agency but which are unavailable. Providers of private duty nursing services are limited to home care service agencies licensed in accordance with the provisions of Part 765 and to private practicing licensed practical nurses and registered professional nurses. Private duty nursing services are presently provided by a licensed home care services agency or a Medicaid enrolled independent provider.

Prior approval by New York Medicaid or the local designee is required for private duty nursing services. **Requests for private duty nursing services should**:

1. Identify the private duty nursing provider;
2. Identify the informal support caregiver;
3. Include a statement from the ordering practitioner that the informal support caregiver is trained and capable to meet <u>all of the skilled and unskilled needs of the patient</u>; and
4. Include a written physician's order which provides diagnosis, medications, treatments, prognosis and other pertinent patient information.

When, at any time, the Medicaid program or the local designee determines that private duty nursing services are no longer clinically appropriate or safe, and the beneficiary continues to request nursing care, the beneficiary is advised of the determination and of the due process rights.

Approval of private duty nursing services is for a period not to exceed six months with required recertification every six months thereafter. Determinations for continued care beyond the initial three months must be approved. See attachment below (Informational Letter 08 OHIP/ INF-5) for supplemental information.

Informational Letter 08 OHIP/ INF-5 addresses frequently asked questions concerning private duty nursing services in the community through the Medicaid program. Guide to Accessing Medicaid Private Duty Nursing Services in the Community advises, in pertinent part:

How does a Medicaid client in the community obtain private duty nursing services?

In general, most new private duty nursing cases are Medicaid clients who have been discharged to the community from a hospital or a nursing facility. In those cases, the hospital or nursing facility discharge planner is primarily responsible for referring the Medicaid client to private duty nursing services, when appropriate. However, Medicaid clients already residing in the community, or their representatives, may also seek to obtain private duty nursing services.

For the Medicaid program to pay for private duty nursing services, the services must be prior approved. The New York State Department of Health reviews and approves or denies prior approval requests for Medicaid clients in most social services districts. The Department's regulations provide that the Department must, with certain exceptions, decide fully-documented requests for prior approvals within 21 days of receipt (10 NYCRR § 85.37). A few social services districts process prior approval requests directly.

The first step in the prior approval process is that the client's physician, or a certified nurse practitioner, must provide a written order that describes why private duty nursing services are medically necessary for that client. The order must describe the client's need for skilled services, including frequency; whether RN or LPN services are recommended; and the number of hours of nursing services that are recommended. This written order may be obtained by the client, the client's parent or by another person acting as the client's representative.

The prior approval request and supporting documentation may be submitted by the client's physician or by the provider that has agreed to furnish the services. The prior approval request must include the name of the particular provider that has agreed to serve the Medicaid client and that provider's category of service, whether a licensed home care services agency or privately practicing RN or LPN.

There are other requirements for obtaining prior approval for new private duty nursing cases. For a more complete description, consult the prior approval guidelines, particularly the "Paperwork Requirements for New Cases," that are contained in the provider manual for private duty nursing services. This provider manual may be viewed at www.emedny.org.

The New York State Medicaid Program Private Duty Nursing Policy Prior Approval Guidelines outline the procedures which govern a prior approval request for LPN services as follows:

Paperwork Requirements for 'New Cases': A "New Case" refers to a client who has never received a Prior Approval number from Medicaid for Private Duty Nursing Services OR there has been a lapse in service. If you are unsure what constitutes a new case, call the Prior Approval office listed in the 'Prior Approval Business Location' section of this website page.

1. Letter of Medical Necessity from ordering physician to include all skilled needs, level of care (LPN or RN) and number of hours being recommended.
2. Nursing Assessment – This is a head-to-toe, system-by-system physical assessment done by an RN. If the client is hospitalized, in a rehabilitation center or skilled nursing facility, an in-house RN can do the assessment. If the client is currently residing at home in the community, then a Certified Home Health Agency (CHHA) or Public Health Nurse (PHN) must do the assessment.
3. Back-up/training statement signed and dated by the primary caregiver, i.e., "In the event a nursing shift is not covered, I will be responsible for taking care of (Beneficiary name), and have been fully trained in all skilled tasks."
4. Documentation of training by facility staff (for hospitalized clients or those in a rehabilitation or Skilled Nursing Facility).
5. Psychosocial Assessment to include:
   a. Who resides in the household with the client (include ages of any children);
   b. Caregiver(s) work schedules on their company letterhead;
   c. If applicable, client's school schedule and calendar;
   d. If primary caretaker is attending college, send course schedule on college stationary.
6. Home assessment done by a Licensed Nursing Agency, PHN or CHHA. If the client is vent dependent, a respiratory company must complete the assessment. This home assessment is to verify the safety of the client's home environment.
7. If there is Primary Insurance, send an Explanation of Benefits (EOB) from the insurance company.
   a. If the client has primary insurance and this is **NOT** disclosed on the Medicaid system, this may significantly delay the Prior Approval process.
8. All skilled tasks must be "specified." For example, do not write suction "PRN," instead, document actual frequency such as suctioned Q 4hrs. For tube feedings – list the actual time of day administered (i.e.: 8a, 12N, 4p, etc.) as well as the name of the product, the amount per feeding and the method (bolus, gravity or pump). Medications must include name of drug, route, dose and frequency.
9. For cases to be staffed by independently enrolled LPN's: a "letter of oversight" signed by the ordering physician must be submitted. This letter should state, "I am aware that there are independently enrolled LPN's staffing this case and I am willing to provide oversight to them." This must accompany the initial prior approval request form (eMedNY361502) along with a list of all Independent providers servicing the case and their NPI numbers.
10. If PDN is for school, then submit a letter from the school district stating child cannot attend without 1:1 nursing and the district cannot provide it, or send a copy of the child's I.E.P.

Upon receipt of a complete package, a medical determination will be given in writing. The provider who has accepted the case can then begin providing services and must submit a Prior Approval Form (eMedNY361502) within thirty (30) days of the initial date of service, to Computer Sciences Corporation, in order to receive the initial Prior Approval Number.

Appendix G to the Managed Long Term Care Partial Capitation Contract advises in relevant part that Private duty nursing services are covered as medically necessary.

Appendix J to the Managed Long Term Care Partial Capitation Contract advises in relevant part that Private duty nursing services as medically necessary are continuous and skilled nursing care provided in an Enrollee's home, or under certain conditions a Hospital or Nursing Home, by properly licensed registered professional or licensed practical nurses.

State of New York, Department of Social Services**,** Memorandum DSS-524EL, dated May 1, 1991, Russell J. Hanks, Policy Clarifications, states, in part: In some cases, an Appellant will provide evidence for the first time during a hearing[,] which was not provided to the social services district at the time the original determination was made. Where the evidence demonstrates that a determination in the Appellant's favor is now appropriate, the decision should indicate that the determination of the district was correct when it was made but that new evidence now requires a different result.

DISCUSSION

The Appellant, age 79, has been in receipt of Medicaid benefits provided through a Medicaid Managed Long Term Care Plan, Independence Care Systems (hereinafter "Plan"). From October 1, 2018 to January 31, 2019, the Appellant was approved for 11 hours/day X 7 days a week of Personal Care Services. On December 4, 2018, the Appellant requested approval for 12 hours day X 2 split shift aides per day for 7 days a week. By Initial Adverse Determination Notice dated December 19, 2018, the Agency determined to deny the Appellant's request for 12 hours a day X 2 split shift aide per day for 7 days a week. Pursuant to the Appellant's internal plan appeal, the Agency issued a Final Adverse Determination Notice date January 4, 2019, "the plan approval **stays** at: Personal Aide Level 2:11 hours per day – 7 days per week – a total of 77 hours per week from December 20, 2018 to May 31, 2019". The Plan explained, "your abilities to perform physical functioning stayed the same for dressing upper and lower body, personal hygiene (cleaning yourself), walking, transfer toilet (getting on and off the toilet), eating, bed mobility (moving around the bed), meal preparation, and ordinary housework. On November 29, 2018, a follow-up face-to-face clinical assessment was performed utilizing the New York State Department of Health's Uniform Assessment System Tool that showed most of your abilities to perform physical functioning stayed the same since your prior assessment that was completed by Centers Plan for Healthy Living on July 31, 2018.

At the fair hearing, the Appellant's Representative testified that the Appellant requires maximum assistance, has frequent incontinence and completely dependent for toileting etc. As evidence the Appellant's Representative provided the Fair Hearing with a night-time log prepared by her daughter which shows that the Appellant needed help with toileting as often as

three times a night on occasions and has a pattern of needing help at night time when she wakes up. The evidence clearly establishes that since no one resides with the Appellant that she has no help at night time

In addition, the November 29, 2018, follow-up face-to-face clinical assessment performed on the Appellant indicates that the Appellant is [redacted] which indicates unscheduled toileting needs day and night. The Plan's registered nursing assessor noted that the Appellant is totally dependent on others for: meal preparation, ordinary housework, bathing and locomotion. The Appellant requires Maximal Assistance with personal hygiene, dressing upper body, and bed mobility. The weight of the evidence supports the Appellant's need for 24-hour, split-shift PCS.

The record in this matter, and the evidence as presented by both parties, has been carefully and fully considered. Based on the evidence offered at this fair hearing, the Appellant's Representatives have met their burden to establish that the Appellant has care needs sufficient to warrant the provision of 24-hour, split shift Personal Care Services. The credible evidence also establishes that the Appellant does have personal care needs, throughout the day and night, which would not allow a 24-hour, live-in personal care aide to receive 5 hours of uninterrupted sleep. The MLTC Plan's Initial Adverse Determination and the MLTC Plan's Final Adverse Determination, are not correct and cannot be sustained.

DECISION AND ORDER

The Plan's determination to deny the Appellant's request for 24-hour, continuous ("split-shift") Personal Care Services (168 hours per week), was not correct.

1. The Plan is directed to provide the Appellant with a Personal Care Services Authorization in the amount of 24 hour daily continuous care through split-shift services.

3. The Plan is directed to notify the Appellant, in writing, of the approval of the Appellant's request for an authorization in the above matter.

Should the MLTC Plan 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 Managed Long-Term Care Plan promptly to facilitate such compliance.

As required by Section 358-6.4 of the Regulations, the MLTC Plan must comply immediately with the directives set forth above.

FH# 7917761M

DATED: Albany, New York
05/06/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee