OHIO DEPT. OF JOB AND FAMILY SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43218-2825

**Ohio Department of Job and Family Services**
**Bureau of State Hearings**

Administrative Appeal Decision

| Appeal | Program | Disposition | Compliance |
|---|---|---|---|
| 3805111 | MED-S | REV | Required |

Request Date: 12/18/2023
Mail Date: 12/28/2023

English

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## Summary

The Appellant requested an administrative appeal of a state hearing decision issued on December 5, 2023. The state hearing decision overruled the Appellant's appeal, finding that CareSource's reduction of the personal care aide (PCA) service hours through the MyCare Ohio Waiver from 40 to 35 per week was correct. Having reviewed the state hearing record, we are reversing the state hearing decision and ordering compliance to CareSource.

## Analysis

The Appellant was previously approved for PCA hours of 40 per week. CareSource conducted a new assessment in September 2023 to determine the number of required PCA hours. From it, CareSource determined the Appellant qualified for 32.25 hours per week but raised it to 35 hours per week. The Appellant completed the appeal resolution process: CareSource upheld the reduction in hours. The Appellant requested a state hearing.

CareSource testified it completed the Aide Norms Tool and reduced minutes allotted to certain tasks because they exceeded the norms. The Appellant argued that she needed the hours she had. The hearing decision overruled her appeal, finding the 35 hours per week to be correct.

The Appellant appealed the hearing decision, indicating the decision relied on an incorrect application of law or rule. She argued that if she had been a different color, the outcome of her hearing would have been different and every year her hours get cut.

The grounds for requesting a state hearing are listed in Ohio Admin. Code §5101:6-3-01(B):

(1) An application for benefits has been denied, acted upon erroneously, or not acted upon with reasonable promptness.

(2) The agency has proposed or acted to reduce, suspend, terminate, or withhold benefits, or the assistance group believes that the level of benefits is not correct.

(3) A request for an adjustment in benefits has been denied, not acted upon, acted upon erroneously, or not acted upon with reasonable promptness.

(4) The agency has determined that an overpayment or overissuance has occurred, or the assistance group believes that the amount of the overpayment or overissuance is not correct.

(5) The individual disagrees with any decision, action, or lack of action involving work registration exemption status or requirements, or work activity exemption status or participation.

A regular employee believes that the assignment of an Ohio works first (OWF) work activity participant violates the prohibition against displacement.

(6) A request for prior authorization of a medical service or additional therapeutic leave days has been denied, or the individual believes that the reviewing agency's decision on a request for pre-certification of a hospital admission or medical procedure is not correct.

(7) The individual or provider of long-term care believes that the level of care assigned, or the effective date of the level of care assigned, to the individual is not correct.

(8) The individual disagrees with a preadmission screening or resident review determination made by the Ohio department of mental health and addiction services or the Ohio department of developmental disabilities.

(9) The enrollment or decision to continue enrollment of the individual in the coordinated services program (CSP), or denial of the individual's request to change a CSP-designated provider.

(10) In regard to actions involving a medicaid managed care plan (MCP) or "MyCare Ohio" plan (MCOP):

(a) The individual disagrees with one of the following actions taken by a medicaid managed care plan:

(i) An MCP or MCOP appeal resolution decision based on an adverse benefit determination, as described in rules 5160-26-08.4 or 5160-58-08.4 of the Administrative Code, as applicable.

(ii) A managed care plan's enrollment or decision to continue enrollment of the individual in the coordinated services program (CSP), or denial of the individual's request to change a CSP-designated provider.

(iii) The plan's upholding the denial of payment for a medical service for

which the individual is being billed.

(b) The individual disagrees with a decision of ODM that the individual does not meet an exclusion from mandatory managed care plan membership, or a decision to deny the individual's request for just cause termination of membership in an assigned managed care plan and enrollment in a different managed care plan.

(c) The MCP or MCOP fails to adhere to the notice and timing requirements for appeals set forth in rule 5160-26-08.4 or 5160-58-08.4 of the Administrative Code.

(11) The agency has denied payment for a medical service provided to an individual enrolled in the coordinated services program (CSP) by a nondesignated provider.

(12) The individual disagrees with any decision, action, or lack of action involving assistance under the supplemental security income (SSI) case management program.

(13) The individual feels that a county board that has medicaid local administrative authority under division (A) of section 5126.055 of the Revised Code for home and community-based services violated the right of an individual to choose a provider that is qualified and willing to provide services to the individual.

(14) In the medicaid program, either the institutionalized spouse or the community spouse may request a hearing concerning the following determinations:

(a) Community spouse monthly income allowance.

(b) Community spouse's minimum monthly maintenance needs allowance.

(c) Family allowance.

(d) Community spouse and institutionalized spouse total gross income.

(e) Spousal share of assessed resources.

(f) Current countable resources.

(g) Community spouse resource allowance.

Discrimination is not a listed ground for a state hearing. The Bureau of State Hearings does not have jurisdiction to hear or rule on that allegation. If the Appellant feels as though she was discriminated against, she can contact the Ohio Department of Medicaid's Employee Relations by one of the following methods:

**E-mail:** ODM_EEO_EmployeeRelations@medicaid.ohio.gov
**Fax:** (614) 644-1434

**U.S. Mail:**
The Ohio Department of Medicaid, Office of Human Resources, Employee Relations
P.O. Box 182709
Columbus, Ohio 43218-2709

**You may also contact:**
Office for Civil Rights, U.S. Department of Health and Human Services
200 independence Avenue, SW
H.H.H Building, Room 509-F
Washington, D.C. 20201
(800) 368-1019
http://www.hhs.gov/ocr.

The case manager completed an Aide Norms Tool as part of the assessment and found that only 32.25 hours of PCA services per week were medically necessary. It found the Appellant required assistance with her activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

Per Ohio Admin. Code §5160-58-03(A)(1), "A MyCare Ohio plan (MCOP) must ensure members have access to all medically-necessary medical, drug, behavioral health, nursing facility and home and community-based services (HCBS) covered by Ohio medicaid. After consideration of verified third party liability including medicare coverage pursuant to rule 5160-26-09.1 of the Administrative Code, the MCOP must ensure: (1) Services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished…."

The rule goes on to state, "The MCOP may place appropriate limits on a service; (1) On the basis of medical necessity for the member's condition or diagnosis…" (Ohio Admin. Code §5160-58-03(B)(1)). To be considered medically necessary a service must meet the

following criteria:

(1) It meets generally accepted standards of medical practice;

(2) It is clinically appropriate in its type, frequency, extent, duration, and delivery setting;

(3) It is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;

(4) It is the lowest cost alternative that effectively addresses and treats the medical problem;

(5) It provides unique, essential, and appropriate information if it is used for diagnostic purposes; and

(6) It is not provided primarily for the economic benefit of the provider nor for the sole convenience of the provider or anyone else other than the recipient (Ohio Admin. Code §5160-1-01(C)).

Further, the rule states, "Just because a medical provider renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a specific treatment or service, does not mean that the specific treatment or service is medically necessary…."

Per Ohio Admin. Code §5160-58-04(C)(16) states covered services include PCA services under Ohio Admin. Code §5160-46-04. Ohio Admin. Code §5160-46-04(A)(1) defines "Personal care aide services" as "services provided pursuant to the person-centered services plan that assist the individual with activities of daily living (ADL) and instrumental activities of daily living (IADL) needs.. . . . Personal care aide services include:

(a) Bathing, dressing, grooming, nail care, hair care, oral hygiene, shaving, deodorant application, skin care, foot care, feeding, toileting, assisting with ambulation, positioning in bed, transferring, range of motion exercises, and monitoring intake and output;

(b) General homemaking activities, including but not limited to: meal preparation and cleanup, laundry, bed-making, dusting, vacuuming, washing floors and waste disposal;

(c) Paying bills and assisting with personal correspondence as directed by the

individual; and

(d) Accompanying or transporting the individual to Ohio home care waiver services, medical appointments, other community services, or running errands on behalf of that individual.

CareSource completed the Aide Norms Tool. It reduced the minutes allotted to following tasks, finding that they either exceeded the norm or were being performed daily instead of weekly:

Bed mobility: -10 minutes

Bathing: -30 minutes

Dressing: -10 minutes

Dusting: -15 minutes

Mopping/vacuuming: -20 minutes

Bathroom/kitchen: -30 minutes.

The Aide Norms Tool shows the norms as being:

Bed mobility: 5 minutes per time

Bathing: 30 minutes per day

Dressing: 15 minutes per day

Dusting: 30 minutes per week

Mopping/vacuuming: 15 minutes per room per week

Bathroom/kitchen cleaning: 15 minutes per room per week.

CareSource testified that the aide notes showed cleaning was being done daily, so it reduced the Appellant's minutes for cleaning by a total of 65 minutes. However, the norms on the Aide Norms Tool shows that 65 minutes per week should be allotted for cleaning. We find that the Appellant's weekly tasks should total 255 minutes.

As for daily tasks, although the Appellant testified that it sometimes takes extra time to do bathing, dressing and bed mobility she provided no evidence. The tool shows the norm for dressing is 15 minutes; for bathing is 30 minutes; for bed mobility is 5 minutes per time. CareSource reduced each to the norm. We find that the daily minutes of 270 are what is needed.

Breaking down the weekly minutes of 255 leads to 36.43 minutes per day (255/7). 36.43+255 daily minutes=306.43 daily minutes/60=5.12 hours per day. We find that the correct number of weekly hours is 40. We are reversing the state hearing decision and ordering compliance to CareSource to approve the Appellant for 40 hours of PCA services weekly.

## Summary

We hereby ORDER that the state hearing decision is REVERSED with COMPLIANCE to CareSource:

1. Rescind the October 4, 2023 notice upholding the approval of 35 hours of PCA services weekly.
2. Approve the Appellant for 40 hours of PCA services, sending written notice of the action taken as a result of this decision via a JFS 04074, 04065, 07334, 07401 or other appropriate state form.

The Appellant retains all state hearing rights regarding any future agency determination..

Susan Lehman
Administrative Appeal Officer

Domingo Ramos
Concur

Kelly Brogan
Chief Legal Counsel
12/28/2023

**Notice to Appellant**

This administrative appeal decision is the final decision on this appeal from the Ohio Department of Job and Family Services and/or the Ohio Department of Medicaid. It is binding on the Departments and agency, unless it is reversed or modified on appeal to the court of common pleas.

If you disagree with the decision, you may appeal it to the court of common pleas pursuant to sections 119.12, 5101.35(E), and 5160.31 of the Revised Code. Mail the original notice of appeal to the department at the following address:

Ohio Department of Job and Family Services
Office of Legal and Acquisition Services
30 E. Broad Street, 31st Floor
Columbus, Ohio 43215-3414

You must also file a copy of the notice of appeal with the court of common pleas in the county in which you reside (Franklin County, if you do not reside in Ohio). Your appeal must be filed within thirty (30) days of the date the decision was mailed to you.

Please note: Any additional information received by the Bureau of State Hearings, relating to this matter, shall be returned to the person who sent it.

If you have questions about appealing to a court, contact your attorney, local Legal Aid Society, or bar association. If you don't know how to reach your local Legal Aid office, call 1-866-LAW-OHIO (1-866-529-6446), toll free, or search the Legal Aid directory at https://www.ohiolegalhelp.org/find-your-legal-aid.