Appealing a Denial or Reduction of Personal Care Services in a Facility

This document explains:

- The changes to the Personal Care Services program and how that affects people living in facilities such as Adult Care Homes, Family Care Homes, and group homes;
- What criteria are used to make the decision about whether or not a person is eligible for Personal Care Services;
- How to appeal a decision about whether a person is eligible for these services;
- The mediation and appeal process each individual may use to keep their services; and
- Step-by-step instructions for how to represent yourself during a mediation and hearing. It is common for people to represent themselves in a Medicaid appeal like this.

What to Do to Fight the Decision and Keep Your Services: File the Appeal Form by the Deadline & Ask to Maintain Services

The letter that reduced or denied your services should come with a Hearing Request Form. You must submit this form within 30 days to protect your right to services. If you file it right away—within 10 days—your services will continue at the level you were receiving before the letter until a final decision is made at mediation or hearing. If you do not have an appeal form with your letter, you can call CCME (800-682-2650) and have the form sent to you.

- If you file your Hearing Request Form by January 10, 2013, there will be no break or change in your aide services until a final decision is made at a mediation or hearing.
- If you file your Hearing Request Form after January 10, 2013, but before January 30, 2013, you may have a break in services for a short period of time until your appeal is received by OAH and services are reinstated.
- Filing the appeal as soon as possible is the best approach to protecting your services and right to appeal.

Appealing the denial notice for your aide services should help keep things the same. If you receive a notice of discharge from your facility, you must appeal the discharge separately.

What are Personal Care Services and why is the service changing?

Personal Care Services (PCS) are services available to individuals with a medical condition, disability, or cognitive impairment who require assistance with certain basic activities of daily living (ADLs), such as eating, bathing, dressing, mobility, and toileting. Generally, to be eligible to receive aide services a person is evaluated for the number of activities of daily living with which they need assistance and...
how much assistance they need. A person must need at least limited hands-on assistance; a need for cueing or prompting to personally perform the task is not sufficient to qualify for services under the PCS program in place January 1, 2013. Although a person may need assistance with activities they want to do, Activities of Daily Living (ADL) is a medical term with a specific meaning when it is used to talk about personal care services. The State decides whether a person is eligible for PCS services based on assessment of the individual’s need for assistance with the ADLs of bathing, dressing, toileting, eating and mobility.

The PCS program offered in North Carolina has changed over the past two years and is changing again as of January 1, 2013, when the State will implement the Consolidated PCS program. The changes to the PCS program will mostly affect individuals who reside in Adult Care Homes (ACHs), Family Care Homes (FCHs), and group homes as these individuals must now meet the same eligibility criteria as people receiving PCS in a private home. The legislature directed the change in the program so that the PCS program would comply with federal Medicaid rules that require that people with similar needs be able to access the same type and level of service. The standard for individuals receiving PCS in a private home has long been different than in facilities. In June 2011, the State made it more difficult to qualify for PCS in private residences and now that same standard is being applied to PCS in facilities.

What is different about Consolidated PCS from the previous PCS plan in facilities?

PCS in the community has been different from PCS in facilities for many years and the Consolidated PCS is an attempt to solve these differences. The major changes include:

- Using independent assessments to determine level of need instead of assessments by the facility. Under Consolidated PCS these assessments are performed by a nurse from the Carolinas Center for Medical Excellence (CCME). CCME assessed people in facilities during the Summer/Fall of 2012 in preparation for Consolidated PCS. CCME has been assessing people for PCS in private homes for several years.
- Granting hours of service based on individual need instead of a daily rate to the facility.
- Referred to as “eligibility”, the standard used to determine if a person qualifies for the service has changed, making it harder to qualify for the services:

<table>
<thead>
<tr>
<th>PCS in Facilities before Jan. 1, 2013</th>
<th>Consolidated PCS (Jan. 1, 2013)</th>
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<tbody>
<tr>
<td>A person requires at least 2 of the following:</td>
<td>A person has unmet need for:</td>
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<tr>
<td>• Ongoing supervision;</td>
<td>• Limited assistance with 3 ADLs; or</td>
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<td>• Medication administration;</td>
<td>• Extensive assistance or full dependency for 2 ADLs.</td>
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<tr>
<td>• Assistance with at least 2 of 7 ADLs at the limited, extensive, or full dependency level (toileting, eating, ambulation, bathing, personal hygiene, dressing and/or transferring); or</td>
<td>Only 5 ADLs are considered: Bathing, eating, dressing, toileting, ambulation, and eating.</td>
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<td>• Assistance with incidental ADLs, including light housework, meal preparation, shopping, errands, use of telephone, money management and use of technology.</td>
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<thead>
<tr>
<th>Data</th>
<th>Consolidated PCS (Jan. 1, 2013)</th>
<th>Consolidated PCS (Jan. 1, 2013)</th>
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| A person has unmet need for:
| • Limited assistance with 3 ADLs; or
| • Extensive assistance or full dependency for 2 ADLs. | Only 5 ADLs are considered: Bathing, eating, dressing, toileting, ambulation, and eating. |
The Independent Assessment—What it is and why it’s important

The letter you received that told you whether or not you were eligible for PCS should have basic information about the ADLs, the level of assistance needed to complete the ADL, and the number of days that assistance would be needed, or “days of unmet need”. This information comes from the independent assessment. The assessment has more information, including: the individual tasks that make up a particular ADL; which of those tasks you did or did not need help with; and a general summary of the assessment.

**Example:** The toileting ADL is assessed by looking at the ability to do the following tasks: (1) Remove/pull up/fasten garments; (2) Hygiene after toileting/incontinence; and (3) Transfer to/from BSC or toilet. The assessment also looks at the IADL tasks of (1) Clean BSC/urinal/bedpan/toileting area; (2) Empty trash, dispose of incontinence supplies; and (3) On-site laundry tasks. The IADL tasks are assessed because if the person qualifies for help with the ADL, they may then qualify for time to have help with the IADL tasks. However, the only tasks that matter for eligibility are the ADL tasks. Once eligibility for the service is established, a person need for help with IADL tasks may be used to get additional time.

The State Assessment is very important because this is the document CCME used to make the decision about the ADLs you need assistance with and how much help you need. Your provider/facility may be willing to help explain the assessment to you. Below is an explanation of how much assistance a person needs is evaluated:

- **Totally Able:** Individual is able to do 100 percent of the activity with or without aids or assistive devices, and without supervision or assistance setting up supplies and environment.
- **Needs Verbal Cueing or Supervision Only:** Individual is able to perform 100 percent of the activity with or without aids or assistive devices, and requires supervision, monitoring, or assistance retrieving or setting up supplies or equipment.
- **Limited Assistance:** Individual is able to do more than 50 percent of the activity and requires hands-on assistance to complete the rest of the activity.
- **Extensive Hands-on Assistance:** Individual is able to do less than 50 percent of an activity and requires hands-on assistance to complete the remainder of the activity.
- **Full Dependence/Cannot Do at All:** Individual is unable to perform any of the activity and is totally dependent on another to perform all of the activity.

When you look at your assessment, you will want to compare how you were assessed by CCME with what your actual needs are. Does the assessment say you only need supervision and you really need the hands-on assistance described in limited or extensive hands-on assistance? The differences between the state assessment and the reality of your day-to-day life are most often the basis for your discussions in the appeal process about why you think CCME was wrong in its assessment of your needs.

**Example:** You look at the state assessment and see that CCME says you need limited assistance with the two ADLs of bathing and dressing. While you agree that you need help in
these areas, you also need help with eating because you need hands-on assistance with preparing your meals and feeding yourself.

**Once a person is eligible, how is the number of hours determined?**

The maximum number in-home care hours is **80 hours per month** for adults (21 years and older) or 60 hours per month for children (under 21 years old) unless the child's need for additional hours is approved under EPSDT.1 Children may have additional tasks, such as ongoing supervision and monitoring, covered under EPSDT that are not covered for adults. The following chart shows how minutes are assigned for qualifying ADLs and IADLs based on the level of assistance required:

<table>
<thead>
<tr>
<th>ADL</th>
<th>Limited Assistance</th>
<th>Extensive Assistance</th>
<th>Full Dependence</th>
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<tbody>
<tr>
<td>Bathing</td>
<td>35</td>
<td>50</td>
<td>60</td>
</tr>
<tr>
<td>Dressing</td>
<td>20</td>
<td>35</td>
<td>40</td>
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<tr>
<td>Mobility</td>
<td>10</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Toileting</td>
<td>25</td>
<td>30</td>
<td>35</td>
</tr>
<tr>
<td>Eating</td>
<td>30</td>
<td>45</td>
<td>50</td>
</tr>
</tbody>
</table>

Time may be authorized for medication assistance with 10 minutes allowed for reminders/set-up; 20 for routine administration (8 or fewer); 40 for routine administration plus administration of “as needed” medications; or 60 minutes for complex or polypharmacy. Time may be authorized for medication assistance services that are allowed by state law in the individuals’ living arrangement.

The Eating ADL includes meal preparation and preparation of texture modified diets, but time is **NOT authorized** for basic meal preparation that duplicates room and board services, which are the basic services a person is expected to receive in a facility.

If the total assigned time for all ADLs is less than 60 minutes per day, the total time is increased to 60 minutes per day. Additional time of up to 25 percent may be authorized for special conditions or circumstances. Additional time up to 25 percent may also be authorized for special assistance and delegated medical monitoring tasks that in total require more than five minutes per day or visit, and for exacerbating and conditions and symptoms that affect the individuals’ ability to perform the ADL.

**How can a person keep their personal care services?**

If you disagree with the denial of eligibility for PCS or the amount of hours of PCS, you can appeal the decision. The pages that follow explain the appeal process, the importance of maintaining services, and how you can self-advocate in this process. A few important things to remember:

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1 EPSDT is an acronym that refers to Early Periodic Screening, Diagnosis, and Treatment, which is a Medicaid benefit for children that requires the State to provide comprehensive and preventive health care for children enrolled in Medicaid. In practice, it allows a child to receive services above a policy limit if medically necessary.
- The ability to appeal the decision is time-limited—you must appeal within 30 days from the date of the letter. If you file your appeal within 10 days from the date of the letter and request that your services continue, you should not have a break in your PCS services.
- You may be able to ask your provider/facility for assistance in the appeal.
- The appeal process does not require an attorney. People are successful in these Medicaid appeals without attorneys every day; all it takes is organization and knowing how to tell the mediator/judge what you need in a way that fits with the definition of the service.

As explained earlier, personal care services have changed significantly over the past several years and more changes are expected. Because of the effect of Consolidated PCS on residents of facilities, it is expected that the legislature will direct the State to make additional changes to the program or create other services for people not eligible for Consolidated PCS. Many people currently living in facilities may not be eligible for Consolidated PCS and the State cannot change the program significantly without legislative direction, which will not happen until 2013 at the earliest and then it will take time to implement. Currently, there are funds set aside to cover expenses for residents of Adult Care Homes who were receiving PCS and are not eligible for Consolidated PCS. It is expected that something similar will be put in place for residents of other facilities, but this is not guaranteed and may still take some time. However, the appeal process should help all residents of facilities keep their current service level for some time if they file an appeal. If you are issued a discharge notice, such as a letter telling you that you have to move, this would be a separate appeal.

**What is Disability Rights NC doing to help?**

Disability Rights NC is working to help resolve the problems created by the changes to the PCS program and has been for several years. In 2011, Disability Rights NC filed a complaint against the State of North Carolina in federal court on behalf of all North Carolina Medicaid recipients whose personal care services were terminated because there were not eligible due to the more strict eligibility criteria put in place as of June 1, 2011. In December 2011, the federal district court judge granted class certification and a preliminary injunction to stop the State from implementing the stricter eligibility standard. The State appealed this decision to the U.S. Court of Appeals and that court granted a stay on the injunction until it can make a decision. Disability Rights NC continues to work on this case and an overall resolution to PCS in North Carolina, how it is used in this state, and what other services or programs may be appropriate to protect the rights of individuals with disabilities to live in the most integrated setting appropriate to their needs.
The Appeal Process & How to Self-Advocate

What is the Appeal Process?
The appeals process is generally a two-step process: Mediation and Hearing.

- **Mediation** - In North Carolina, before you get to a hearing you will have an opportunity to discuss your need for in-home aide services through mediation. This is an informal process in which both parties are guided through a discussion by a neutral, third-party mediator to see if they can reach an agreement.

- **Hearing** - If mediation does not resolve the issue, the next step is a hearing at the NC Office of Administrative Hearings (OAH) before an Administrative Law Judge. The hearing involves presenting evidence, including introducing documents, allowing someone to testify on your behalf, and making arguments to an Administrative Law Judge.

Remember, Medicaid appeals are intended to allow a person to appeal a denial or reduction of a Medicaid service with or without an attorney. Although an attorney can be helpful, people are often successful in Medicaid appeals on their own or with the help of a trusted relative or friend. Your provider/facility may also be willing to assist you. The keys to success are: know your rights, be organized, and present information to the Administrative Law Judge that shows your medical need and explains why you qualify for personal care services.

Step 1: File the “Hearing Request” Form.
The Hearing Request Form is enclosed with the letter informing you of your denial.

- Instructions on how to file this form are on the form itself. The form must be returned by mail or by fax at (919) 431-3100 to the NC Office of Administrative Hearings (OAH) to appeal the termination of your in-home aide services.

- **In order to appeal your termination of services, the Hearing Request Form must be submitted to OAH within 30 days from the date on the denial letter or you may lose your right to appeal.**

- Most hearings will be done over the telephone. However, you can request an in-person hearing. If you request an in-person hearing, it will be in Raleigh, unless you request otherwise. You can request that the hearing to be in your county of residence if you can show “good cause,” such as your disability prevents you from traveling to Raleigh.

The letter you received says that you may be required to pay for the services that continue because of your appeal. While this is possible if you ultimately lose at a hearing, it does not generally occur.
Step #2: Preparing for Mediation.

Within 25 days of filing your appeal, you will be contacted by a mediator to schedule a time to discuss your denial of in-home personal care service with the representative from DMA. This is a mediation, and it will likely take place over the telephone.

- **Who is Involved in Mediation** – If you are not represented by an attorney, the parties at the mediation will be a neutral, third-party mediator, yourself, and a representative from the Carolinas Center for Medical Excellence (CCME).
  - Your doctor, nurse, aide, case manager or family member can participate in the mediation to explain your need for the services.
  - CCME is an organization contracted by DMA to conduct reviews of requests for services. A CCME nurse likely came out to your home within the last year to perform an assessment of your ADL needs.
  - If you are represented by an attorney, an Assistant Attorney General representing DMA will also participate in the mediation. Make sure to let the mediator know that you are being represented by an attorney.
- **Gather Documents** – Organize any information or records you have documenting your medical need for personal care services.
- **Request Documents** – You are entitled to see the information that was used by CCME when it made its decision to terminate your personal care services. You can request a copy of your DMA case file, including your most recent State Assessment, by contacting the Assistant Attorney General assigned to your case in the NC Department of Justice, Division of Health and Public Assistance at 919-716-6855. (See next section explaining State Assessment)
- **Share Documents** – If you have documents, such as a letter from your doctor, that you would like CCME to see prior to mediation that will facilitate your discussions you can provide a copy directly to the mediator, who will give it to the CCME representative.
- **Witnesses** – Your in-home aide and/or doctor would serve as the best witnesses regarding your medical need for personal care service. He or she can provide a letter or affidavit (a notarized, signed statement) explaining why you have a medical need for personal care services.
- **Have a Number of Hours In Mind** – Be ready to explain what would happen if you do not get in-home aide services. It may be that CCME says they will do a new assessment, or CCME may offer you a certain number of hours of in-home personal care, but it is less than what you were receiving. Have in mind the number of hours of personal care service you feel will allow you to continue on living independently. If you are willing to settle for a lesser number of hours, you may be able to resolve the case at mediation and avoid a hearing.

**Appealing a Cut in Hours vs. a Denial of Services**

Regardless of whether you have a cut in hours or a complete denial or termination of your in-home aide services, you must be able to show you need the service. However, when your hours are cut you should be prepared to explain or show:

- How all the hours you have been receiving are necessary. Your provider is required to create a plan for your care and you should be able to use this plan the help show why all of the time is
necessary. You can also add to this information your own personal experience as to why it takes that amount of time do a certain task.

- That there is no inefficient in the time for the care being provided. A cut in hours usually means that when your services were reviewed someone thought the services could be provided in a shorter amount of time.
- That the in-home aide services in particular are necessary to do a task rather than other services. For example, if you receive Meals on Wheels and also get help from your aide with meal preparation you need to show how they are both necessary.

**Step#3: The Mediation.**

Mediation is a voluntary and confidential process. There is no penalty if you do not arrive at a settlement during mediation. There are advantages to mediation, including settling the issue or investigating the reasoning behind the decision to terminate services prior to a hearing. There is nothing to lose at mediation. If you do not settle at mediation, you simply go on to a hearing at OAH. The information you gather during mediation can be used to make better arguments during the hearing.

- In as much detail as possible, emphasize and focus on the types of hands-on assistance you need with any of the five activities of daily living (ADLs) of bathing, dressing, toileting, mobility, and eating.
- Your State Assessment shows which tasks are associated with each Activity of Daily Living. These can give you an idea about what to include in your discussion.
- For example, an individual who needs help with getting dressed would discuss the types of hands-on assistance they need with putting on, fastening, and removing clothes, socks and shoes. An individual who needs help with mobility would discuss the type of hands-on assistance they need with moving to and from their bed, to and from a chair, from one room to another room, or going up and down stairs.

Instead of an offer of hours, CCME may also offer to do a new assessment. This may be especially true if you are arguing that the information in the assessment is wrong. A new assessment would be an opportunity to show what your needs are and the level of assistance you need with the ADLs they evaluate.

If you are offered a level of personal care services you feel will allow you to continue on living independently, without putting your health and safety at risk, you may decide to accept the offer and agree to a settlement of your appeal. The offer may not be available later at the hearing. If you are offered a settlement that you do not think will allow you to continue living independently, you can choose not take it. There is no penalty for saying “no” to a settlement offer at mediation. You will move on to the next step, which is an evidentiary hearing at OAH.

**Step #4: The Hearing.**

If you did not settle your case at mediation, the next step will be an evidentiary hearing. This means a hearing where both sides present evidence and witnesses to explain why you do or do not qualify for in-home personal care service.
• **Who is Involved at Hearing** - You can find out which Assistant Attorney General is assigned to represent DMA in your appeal by calling the NC Department of Justice, Division of Health and Public Assistance at (919) 716-6855.

• **Evidence** – Any evidence in support of your case, such as a letter from your doctor, must be submitted to OAH and the Assistant Attorney General assigned to your case **7 days** prior to a hearing.

• **Witnesses** – Your doctor, nurse, aide, case manager, family members, or anyone who can testify to your medical need for personal care services can be a witness.
  o Witnesses can testify by phone if they are not available to attend the hearing in person.
  o You should check your witnesses’ schedules to make sure they are available on the date of your hearing. If they are not, this may be good cause for requesting a continuance, or a later court date, from OAH.

• **ALJ’s Recommended Decision** - The Administrative Law Judge will issue a decision in your case within **20 days** of the hearing, either agreeing or disagreeing with DMA’s decision to terminate services.

• **Final Agency Decision** - DMA can either adopt or reject the Administrative Law Judge’s decision in your case. Prior to issuing its Final Agency Decision, DMA is required to give you an opportunity to file “Exceptions” to explain why you agree or disagree with the Administrative Law Judge’s decision. If DMA reverses the Administrative Law Judge’s decision, they must give detailed facts and reasons that support the reversal. The Final Agency Decision will be mailed to you.
  o If the Final Agency Decision reverses the Administrative Law Judge’s Recommended Decision, you can appeal to Superior Court within **30 days** from the date of the Final Agency Decision. This is done by filing a Petition for Judicial Review in the Superior Court in the county where you reside or Wake County Superior Court. If you feel the need to appeal your case to Superior Court, you should contact an attorney to assist you with this process.

Disability Rights North Carolina is a federally mandated protection and advocacy system with funding from the U.S. Department of Health and Human Services, the U.S. Department of Education, and the Social Security Administration. Disability Rights NC is a 501(c)(3) nonprofit charitable corporation.

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