Case Example Mr. S., Flushing NY - Senior Health Partners

Had 12 hours x 7 days personal care. Age 96. He had home care since 1997 through CASA, and then was mandatorily transitioned to MLTC. He has changed plans at least once – reasons are unclear as to why or how. He has dementia and his care is managed by family. He has been in the current plan since around July 2013.

11/19/2013 - Plan gave "Projected Service Plan for Member" with effective date the same as the date of the document – 11/19/13, stating recommend hours were 8 hours x 7 days. Member was asked to sign the plan – given that he has dementia and is Russian-speaking it is not clear that he understood what he signed. If this was supposed to be a notice of reduction, it fails in many respects – it was not given at least 10 days before the reduction, did not state that hours were being reduced and why, and lacked information on how to request an internal appeal and any explanation of "aid continuing" rights.

The plan provided an appeal form titled "Denial of Benefits under Managed Long Term Care" that gives instructions for requesting a Fair Hearing but says nothing about how to request an internal appeal, let alone the requirement that an internal appeal must be requested first. It is unclear if FH was requested, but if it was it would have been dismissed for failure to exhaust.

On Dec. 10, 2013, hours were cut to 8 hours x 7. Family called immediately to contest the reduction and submitted a medical letter in support. The plan failed to issue a decision on the appeal for over **three months**, leaving the member in limbo and with services cut the entire time. (The time limit for an internal appeal decision is 30 days, or only 3 days if appeal is expedited because of jeopardy to health).

By notice dated Mar. 19, 2014, plan denied the internal appeal with a "DENIAL OF BENEFITS." This notice does not even acknowledge that the issue involved a REDUCTION in hours, failing to explain why a reduction from 12 to 8 hours/day was justified, violating *Mayer v. Wing* as codified in 18 NYCRR 505.14(b)(5)(c).

Mr. S has multiple health diagnoses that necessitate 12 hours x 7 days of home care --chronic pneumonia, asthma, edema, and fluid retention in lungs. He has an unsteady gait and balance issues, requiring assistance with all ADLs. ***Since the reduction in his personal care hours, Mr. [redacted] has fallen three times when the aide was not present***. Two of these falls required medical attention. The family reports that Senior Health Partners was aware of at least one of these hospitalizations, but did not intercede to reverse the reduction in his plan of care. Due to his chronic pneumonia, asthma, and fluid retention in his lungs Mr. S must be reminded to use his nebulizer in the morning when he wakes up and again before he goes to bed. Prior to the reduction, his aide reminded him to use the nebulizer around 8 am and then before she left at 8 pm. After the reduction, the aide reminded him to use the nebulizer in the morning and again at 3:45 pm – four hours earlier than before --- which led to unnecessary buildup in his lungs.

Care was only restored after NYLAG filed a complaint with the State DOH on May 14th.

☐ Start of Enrollment
☑ Reassessment

Senior Health Partners
Managed Long-Term Care Plan
A HealthFirst Company

Projected Service Plan for Member

Name: [redacted] EMR # [redacted]

Projected Service Date: 11/19/13 Assessment Period from _____ to _____

Projected Services:

☑ Nursing Recommended frequency: q 6 month

Assess and monitor cardiopulmonary, neurovascular, musculoskeletal, gastrointestinal, genitourinary, cognitive, functional, skin integrity, nutrition and hydration status; instruct and supervise medications; instruct diet; provide support; reinforce home safety. Other: _____

☑ PCA/HHA Recommended days/hours: 7days x 3hrs

Name of vendor, if known: _____

Assist with personal care including bathing, dressing, grooming, toileting, skin care as needed; monitor skin integrity. Assist in ambulation and transfers as needed. Assist with meal preparation per recommended diet; medication reminders as needed; assist with shopping, accompany to MD appointments and errands. Perform light housekeeping. clean client's bathroom, kitchen bedroom and living areas; laundry, mop, sweep/vacuum floors.

☑ Nursing: q 6 month
☐ Housekeeping
☐ Initial Psychosocial Evaluation
☐ Physical Therapy Evaluation
☐ Speech Therapy Evaluation

☑ PCA/HHA: 7d/ x 3hrs
☐ Heavy Duty Housecleaning
☐ Home Repair
☐ Occupational Therapy Evaluation
☐ Nutrition Evaluation

☐ Adult Day Health Center: ☐ Social Day Center: ☐ Evaluation ☐ Currently attending
☐ Medical Model: ☐ Evaluation ☐ Currently attending

Name of Center if currently attending: _____
☐ PERS ☐ Safe Return Bracelet ☐ Medical ID Bracelet
☐ Transportation ☐ Audiology ☑ Dental ☑ Podiatry ☑ Optometry bath bench
☑ Medical Equipment: walker, cane, wheelchair, commode
☑ Medical Supplies: diapers, pull ups,
PCP Name: Nguyen, E Telephone # 718 576 4652
PCP Address: _____

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NURSING	PCA	COVERED SERVICES
☑ Member/Caregiver will reach optimal functioning	☐ HHA/PCA/ Housekeeping	☑ Member will receive an audiology evaluation
☑ Member/Caregiver verbalize understanding and will follow medication regimen	☑ Member will remain safe at home with supervision	☑ Member/caregiver verbalizes understanding of the importance of an annual audiology exam
☐ Member/Caregiver will demonstrate understanding of the disease process and treatment plan.	☑ Maintain a clean home	☐ Member will receive needed hearing aids
☑ Member/Caregiver will keep an up to date list of current meds and verbalizes an understanding of the signs/symptoms related to the medication	☑ Provide medication reminders	☑ Member will receive a podiatry exam
☑ Member/Caregiver will address individual barriers to improve overall well-being and meet personal health goals	☑ Assist member with activity of daily living (i.e. bathing, grooming and transfer) and independent activities of daily living i.e. grocery shopping and laundry	☑ Member/caregiver verbalizes an understanding of the importance of a podiatry visits
☑ Member/Caregiver will make and keep follow up appointments have annual health screening, counseling and immunizations	☑ Escorts to and from medical appointments	☑ Member will receive an annual eye exam
☑ Member will inform the team if there are any health related changes	☐ If HHA: Assist with treatments as ordered	☑ Member/caregiver verbalizes understanding of the importance of an annual eye exam
SOCIAL DAY	PERS	☐ Member will receive an dental visit
☐ Utilize community resources to enhance members socialization	☐ Member/caregiver verbalizes when and how to access emergency care	☑ Member/caregiver verbalizes understanding of the importance of annual dental visits
☐ Member will receive Medical Treatment as needed while attending the Medical Model Day Center		
PHYSICAL THERAPY	OCCUPATIONAL THERAPY	NUTRITIONAL ASSESSMENT
☐ Member will show improved activity of daily living performance	☐ Member will show improved motor skills	☐ Member will receive nutritional evaluation
☐ Member will show improved strength and coordination	☐ Evaluate the home and establish a plan for optimal functioning	☐ Verbal counseling needed
☐ Evaluate appropriate medical equipment needs	PSYCHOSOCIAL	HEAVY DUTY HOUSEKEEPING
☐ Educate member on fall precautions	☐ Member will be provided with continued counseling	☐ Member's home will be eliminated of infestation and clutter
☐ If eligible, enroll in SHP Fall Prevention Program		☐ Maintain a clean environment
☐ Member will safely function in home with devices		
SAFE RETURN BRACELET	TRANSPORTATION	
☐ Identify member's with cognitive/memory deficits	☑ Caregiver/Member will be provided safe transportation to all medical appointments	
☐ Promote safe return of member	☐ Caregiver/Member will be provided safe transportation to Social/Medical Model Day Centers	

Your finalized Service Plan will be mailed to you by your Care Management Team.

Member/Representative Signature: [redacted] Date: 11/19/13

Assessment Nurse Signature: [signature] Date: 11/19/13

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DENIAL OF BENEFITS UNDER MANAGED LONG TERM CARE

SENIOR'S HEALTH PARTNER'S
MLTCP's Name

RIGHT TO A FAIR HEARING : If you believe that the action we have taken is wrong, you can ask for a State fair hearing by phone or by writing.

1. **TELEPHONE:** Statewide Toll Free 1-800-342-3334. Please have this notice with you when you call.
2. **FAX:** Fax a copy of all the pages of this notice to (518) 473-6735.
3. **WALK-IN:** Bring a copy of all the pages of this notice to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 330 West 34th Street, 3rd floor, New York, N.Y. – or - 14 Boerum Place, 1st floor, Brooklyn, New York.
4. **TO WRITE FOR A FAIR HEARING:** Fill in the space below and send a copy of all pages of this notice to:

   Fair Hearing Section
   NYS Office of Temporary and Disability Assistance
   Fair Hearings
   P.O. Box 22023
   Albany, N.Y. 12201-2023

   Please keep a copy for yourself.

5. **OR ONLINE ON THE INTERNET**. Complete the online request form at the following Web page:

   https://www.otda.state.ny.us/oah/oahforms/erequestform.asp

✓ **I want a fair hearing:** This action is wrong because The hours were taken away with out any reason or explanations.

Client Signature: (X) [redacted]

Client print name here: [redacted]

Client Address: [redacted] Flushing, N.Y. 11367

Phone Number: (718) [redacted] Case Number: _____ CIN Number : _____

MEMBER ID#: [redacted]

YOU MUST ASK FOR A FAIR HEARING WITHIN 60 DAYS FROM THE DATE OF THIS NOTICE

IF YOU ASK FOR A FAIR HEARING, the State will send you a notice with the time and place of the hearing. You have a right to bring a person to help you like a lawyer, a friend, a relative or someone else. At the hearing, this person can give the hearing officer something in writing or just tell why the action should not be taken. This person can also ask questions of any other people at the hearing. Also you have the right to bring people to speak in your favor. If you have any papers that will help your case – pay stubs, receipts, health care bills, doctor's letters – bring them with you.

IF YOU NEED FREE LEGAL HELP, you may be able to get such help by calling your local Legal Aid Society or advocate group. To locate a lawyer, check your Yellow Pages under "Lawyers" or call the number on the front of this notice.

(1)

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YOU HAVE A RIGHT TO SEE YOUR CASE FILE to help you get ready for the hearing. If you call or write to us, we will give you free copies of other documents from your file, which you may want for your fair hearing. To ask for these documents or to find out how to see your file, call the general Help telephone on the front page or write to us at the address at the top of the front page. You should ask for these documents before the date of your fair hearing. If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you ask that they be mailed.

FOR MORE INFORMATION ON YOUR CASE: If you want to see your file, to find out how to ask for a fair hearing or to find out how to ask for copies of your file, call the number or write to the address on the top of the front page of this notice.

(2)

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March 19, 2014

(NYC – rev. 3/29/05)

Managed Long Term Care Plan Action Taken
Senior Health Partners
DENIAL OF BENEFITS

NOTICE DATE: 3/19/14	**NAME, ADDRESS AND TELEPHONE OF MLTCP:**
CASE NUMBER: / **CIN NUMBER:** VE[redacted]	Senior Health Partners 100 Church Street New York, NY 10007
ENROLLEE NAME AND ADDRESS: S[redacted] [redacted] **FLUSHING, NY 11367**	**GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP** (212) 324-2600

This is to inform you that your request for: **ADDITIONAL PATIENT CARE AIDE SERVICES.** has been denied by your Managed Long Term Care Plan through their appeals process on: **3/19/14** because: You are alert and oriented although forgetful at times and can perform your ADL's (Activities of Daily Living) with assistance. You were reported to have recently sustained falls where no injuries were noted and medical treatment was not required. In regards to your recent hospitalization, you were reported to have been treated and discharged home in stable condition with outpatient follow-up. You live with your daughter and have family support. The recommendation is for 7-days x 8-hours of Patient Care Assistant services per week. The Care Management Team with continue to assist you in your healthcare needs and monitor any changes in your status and adjust your services accordingly.

This action is taken under 42 CFR Part 438. If you think this action is wrong, you may ask for a "State Fair Hearing." To learn how to do this, please read the back of this sheet that says: "RIGHT TO A FAIR HEARING."

Distribution:
Client/Fair Hearing
Client copy
Managed Long Term Care Plan

(3)

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y_NEW YORK STATE EXTERNAL APPEAL APPLICATION

New York State Insurance Department, PO Box 7209, Albany NY, 12224-0209

If an HMO or insurer (health plan) denies health care services as not medically necessary, experimental / investigational, a clinical trial, a rare disease treatment, or out-of-network, complete and send this application to the above address within 45 days of the plan's final adverse determination. For help call 1-800-400-8882 or e-mail your questions to externalappealquestions@ins.state.ny.us.

TO BE COMPLETED BY ALL APPLICANTS

1. **Applicant Name:**

(Please check one) [V]Insured/Patient [ ]Patient's Designee [ ]Provider

2. **Patient Name:** [redacted]

3. **Patient Address:** [redacted]

Flushing NY, 11367

4. **Patient Phone Number:**
Home(718) [redacted] Work( ) -

5. **Patient E-mail (if patient submits application and wants contact by e-mail):**

6. **Health Plan Name:** HealthFirst / Senior Health Partner

7. If the patient is covered under a Medicaid Managed Care Plan, has the patient requested a fair hearing through Medicaid or received a fair hearing determination? (Please check one.)
[ ]Yes [ ]No [ ]Don't know

8. **Reason for Health Plan Denial:** (Please check one.)
[ ] Not medically necessary. [V] Experimental / investigational.
[ ] Clinical trial. [ ] The treatment is for a rare disease.
[ ] Out-of-network and the health plan proposed an alternate in-network service.

9. Describe the service and the date(s) of service. **Attach the final adverse determination from the first level of appeal with the health plan, or the health plan's letter waiving the appeal,** along with any other information you would like considered.

The patient had 7days x 12 hours aide services up until 12/10/13, and then the services were cut to 7days x 8 hours without any explanations. (authorizations to vendors attached)

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