State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
4190 Washington Street, West
Charleston, WV 25313
Phone: 304-746-2360, Extension 2227

Earl Ray Tomblin
Governor

Michael J. Lewis, M.D., Ph.D.
Cabinet Secretary

February 23, 2012

----------for

Dear ----------:

Attached is a copy of the Findings of Fact and Conclusions of Law on your hearing held February 23, 2012. Your hearing request was based on the Department of Health and Human Resources' decision to deny request for increased respite and therapeutic consultant services.

In arriving at a decision, the State Hearing Officer is governed by the Public Welfare Laws of West Virginia and the rules and regulations established by the Department of Health and Human Resources. These same laws and regulations are used in all cases to assure that all persons are treated alike.

Eligibility for the I/DD Waiver is based on current policy and regulations. These regulations provide that for respite care and therapeutic consultant services, the amount of service is limited by the member's individualized budget and increase adjustments are made only when changes have occurred regarding the member's assessed needs. (West Virginia Medicaid Regulations, Chapter 513 – Covered Services, Limitations, and Exclusions, for I/DD Waiver Services)

The information submitted at your hearing revealed that there was insufficient information provided to the Department for consideration that supports that a change occurred regarding the Claimant's assessed needs.

It is the decision of the State Hearing Officer to **Uphold** the action of the Department to deny Claimant's request for increases in respite and therapeutic consultant I/DD Waiver services.

Sincerely,

Cheryl Henson
State Hearing Officer
Member, State Board of Review

cc: Chairman, Board of Review
APS Healthcare / Patricia Nisbet

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

IN RE: ----------,

Claimant,

v. **ACTION NO.: 12-BOR-321**

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES,

Respondent.

DECISION OF STATE HEARING OFFICER

I. INTRODUCTION:

This is a report of the State Hearing Officer resulting from a fair hearing for ----------. This hearing was held in accordance with the provisions found in the Chapter 700 of the West Virginia Department of Health and Human Resources' Common Chapters Manual. This fair hearing was convened on February 23, 2012.

II. PROGRAM PURPOSE:

The Intellectual and Developmental Disabilities (I.DD) Waiver Program is West Virginia's home and community-based services program for individuals with intellectual and/or developmental disabilities. It is administered by the Bureau for Medical Services pursuant to a Medicaid waiver option approved by the Centers for Medicare and Medicaid (CMS). The I/DD Waiver Program reimburses for services to instruct, train, support, supervise, and assist individuals who have intellectual and/or developmental disabilities in achieving the highest level of independence and self-sufficiency as possible. The I/DD Waiver Program provides services in natural settings, homes and communities where the individual resides, works and shops.

III. PARTICIPANTS:

----------, Claimant
----------, Claimant's Mother
----------, Claimant's Therapeutic Consultant
----------, Claimant's Service Coordinator

Jennifer Eva, APS Healthcare
Pat Nisbet, Department Witness

Presiding at the Hearing was Cheryl Henson, State Hearing Officer and a member of the Board of Review.

IV. QUESTION TO BE DECIDED:

The question to be decided is whether the Department was correct in its decision to deny the Claimant's request for increased respite and therapeutic consultant services.

V. APPLICABLE POLICY:

West Virginia Medicaid Regulations, Chapter 513 – Covered Services, Limitations and Exclusions, For I/DD Waiver Services

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 Excerpts from West Virginia Medicaid Regulations, Chapter 513.9.1.10 I/DD Waiver Services
D-2 Excerpts from West Virginia Medicaid Regulations, Chapter 513.9.1.15 I/DD Waiver Services
D-3 Notice of Denial dated December 7, 2011
D-4 APS CareConnection View Purchase Request Details for Budget Year 11/1/2011 – 10/31/2012
D-5 APS CareConnection Inventory for Client and Agency Planning report dated August 5, 2011
D-6 APS CareConnection Inventory for Client and Agency Planning report dated August 24, 2010

VII. FINDINGS OF FACT:

1) Claimant was actively receiving services under the Intellectual and Developmental Disabilities, hereinafter I/DD Waiver Program, when on or about October 25, 2011, the Department completed an annual re-evaluation of her level of care services based on submitted requests for approval of services received from the Claimant and her service coordination agency or team. The Department sent the Claimant a denial notice on December 7, 2011, which included the following relevant information:

> A decision has been made regarding your team's request for a 2nd Level Review of I/DD waiver service(s). Your request to increase your amount of service was not determined to be clinically necessary and is denied.

	Requested Units	Approved Units
Respite – Agency (1:1)	5310	2920
Therapeutic Consultant	900	480

2) The Department representative, Jennifer Eva, is employed with APS Health Care services. She stated that she supervises the employees that go out annually and conduct assessments (D-5, D-6) for recipients. She added that information gathered by these employees from family and treatment providers during the assessments is ultimately used to determine an individual's yearly budget.

Ms Eva stated that based on the findings of the August 5, 2011 assessment (D-5), the Claimant was assigned a yearly budget (D-4) for fiscal year November 1, 2011, through October 31, 2012, in the amount of $52,296.94, to pay for services the Claimant needs throughout that fiscal year.

Ms. Eva stated that the Claimant, along with her family members and members from her service coordination agency, meet annually to determine what the Claimant's clinical needs are for any given fiscal year and they submitted requests for approval of the various determined needed services for the fiscal year of November 1, 2011, through October 31, 2012, through the Department's CareConnection computer system (D-4).

Ms. Eva stated that when the Department considered the Claimant's submitted requests, which included 5310 units for Respite-Agency care and 900 requested units for Therapeutic Consultant, the Claimant's total requested services exceeded her allowed budget of $52,296.94 by $28,879.50. She explained that each "unit" equals fifteen (15) minutes of services.

However, Ms. Eva added that even though the Claimant's requests exceeded her budget, the Department continued to look for evidence of a change in clinical need in the submitted information. She added that the only information available for review was the Claimant's CareConnection Inventory for Client and Agency Planning assessment reports (D-5, D-6) from August 5, 2011 and August 24, 2010.

Ms. Eva stated that in reviewing the reports, she found that there was no significant change in functioning which would indicate a clinical need for increased services, and that the Department's denial was based on that determination. She added that because the assessment reports contain the results of information derived from the Claimant and family and not from the Department, it is an objective assessment process. She stated that in comparing the 2011 report to the 2010 report, there are no changes in the Claimant's residential status or day program status. She stated that the Claimant's 2011 general score in the maladaptive behavior area has improved since 2010, and her 2011 adaptive behavior scores are comparable to 2010 with little change. She added that the Claimant's service score for 2011 was 54, compared to a 2010 score of 53, which places

the Claimant in a service level of 5 for both scores. Furthermore, she stated that these scores tell her that the Claimant is functioning clinically at the same level during 2011 as she was in 2010. She added that the Department received no further documentation for consideration.

3) The Claimant's mother and representative is ----------. She agreed that the August 25, 2011 assessment report (D-5) is an accurate portrayal of the Claimant's functional abilities. She stated that there has not been much change in the Claimant's functional level; however, she stated that during the year 2010 the Claimant received twice as many units, and that she is concerned that she will not receive the same level of care as a result of the reduced units. She stated that the Claimant cannot be left alone at home and that she also has another child with the same diagnosis and needs as the Claimant that requires her individual attention. She stated that with the reduced units, she has had to give attention and instruction to both her children at the same time, rather than individually.

Ms. Eva addressed the reduction in units from 2010 versus 2011 by saying that the policy has changed for program year 2011.

Pat Nisbet is the Program Manager for the Department's Bureau for Medical Services. She pointed out that the Claimant is receiving Person Centered Support of 6 hours daily, as well as Person Centered-Agency support services of 1.6 daily. Furthermore, she stated that the Claimant is also approved for 2.0 hours daily of Respite services, which totals 3.6 hours daily that someone else cares for her child. She also added that the Claimant has the option of applying for her individual services either as a 1 to 1 ratio, or a 1 to 2 ratio. She explained that by selecting the 1 to 2 ratio, she would be able to work with both her children at the same time and this may also free up some funds for use in other areas.

The Claimant's mother stated that she understands that she has a budget, and added that she can work with the Department's approved services.

4) West Virginia Medicaid Regulations, Chapter 513.9.1.10 states in relevant part:

> Respite
>
> All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.
>
> Respite Agency services may be used to: allow the primary care-giver to have planned time from the caretaker role; provide assistance to the primary care-giver in crisis and emergency situations; and ensure the physical and/or emotional well-being of the primary care-giver by temporarily relieving them of the responsibility of providing care.

Limitations/Caps

The amount of service is limited by the member's individualized budget.

The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.

5) West Virginia Medicaid Regulations, Chapter 513.9.1.15 states in relevant part:

Therapeutic Consultant

All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

The Therapeutic Consultant may perform the following functions: develops task analysis and person specific strategy or methodology for implementation of intervention or instruction plans for an individual; evaluates environment(s) for implementation of the plan which creates the optimal environment for learning; assists members in selecting the most suitable environment for their learning needs; trains primary direct workers (i.e., person-centered support workers, facility-based day habilitation workers, supported employment and respite workers) in person-specific aspects and methods of intervention or instruction plans (habilitation plans or guidelines); assesses, evaluates and monitors the effectiveness of intervention or instruction plans (habilitation plans or behavioral guidelines) for habilitation training; collects and evaluates data and completes a functional assessment around targeted behaviors to generate a recommendation for a Positive Behavior Support plan; Provides direct care services when needed and bills the appropriate direct care service code; attends and participates in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO when requested by the member or their legal representatives; and presents proposed member's restrictive measures to the I/DD Waiver provider's Human Rights Committee if no other professional is presenting the same information.

Limitations/Caps

The amount of service is limited by the member's individualized budget. The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.

VIII. CONCLUSIONS OF LAW:

1) Regulations specify that for respite services and therapeutic consultant services, the amount of the services is limited by the member's individualized budget, and that increases or decreases in the budget amount may only be made if changes have occurred regarding the individual's assessed needs.

2) Documentation supports that the requested 5310 respite units and 900 therapeutic consultant units causes the Claimant to exceed her individualized budget, and there was insufficient evidence to support that changes have occurred regarding the Claimant's assessed clinical needs. The Claimant's mother testified that there has been little change in the Claimant's assessed clinical needs from 2010 to 2011, and the written documentation supports her testimony.

IX. DECISION:

It is the decision of the State Hearing Officer to **uphold** the decision of the Department to deny the Claimant's request for increased respite and therapeutic consultant services.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 23rd day of February, 2012.

Cheryl Henson
State Hearing Officer