State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
2699 Park Avenue, Suite 100
Huntington, WV 25704

Earl Ray Tomblin
Governor

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

April 23, 2012

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Dear ---- ----:

Attached is a copy of the Findings of Fact and Conclusions of Law for ---- ---- ----'s hearing held February 29, 2012. The hearing request was based on the Department of Health and Human Resources' denial of a requested increase in services under the Intellectual and Developmental Disabilities (I/DD) Waiver Program.

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 services under the I/DD Waiver Program is based on current policy and regulations. Policy for all the requested services states that all units of service must be prior authorized before being provided, and that prior authorizations are based on assessed need and services must be within the member's individualized budget (West Virginia Medicaid Provider Manual, Chapter 513 – I/DD Waiver Services, effective October 1, 2011; §513.9.1.1, §513.9.1.8.1, §513.9.1.8.2, §513.9.1.10.1, §513.9.1.12.1).

Information submitted at the hearing revealed no documented clinical change in the underlying condition of ---- ---- warranting either an increase or decrease in services.

It is the decision of the State Hearing Officer to **uphold** the Department's denial of a requested increase in services through the I/DD Waiver Program, and to **reverse** any Department proposal to reduce services.

Sincerely,

Todd Thornton
State Hearing Officer
Member, State Board of Review

cc: Erika H. Young, Chairman, Board of Review
Pat Nisbet, Department Representative
Jennifer Eva, Department Representative

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

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

Claimant,

v. **ACTION NO.: 12-BOR-331**

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 concluded for ---- ----. This hearing was held in accordance with the provisions found in the Common Chapters Manual, Chapter 700 of the West Virginia Department of Health and Human Resources. This fair hearing was convened on February 29, 2012, on a timely appeal, filed December 22, 2011.

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 representative
---- ----, Claimant's witness
---- ----, Claimant's witness
Pat Nisbet, Department representative
Jennifer Eva, Department representative
Nora Oscanyan, Department's witness

Presiding at the Hearing was Todd Thornton, State Hearing Officer and a member of the State Board of Review.

IV. QUESTION TO BE DECIDED:

The question to be decided is whether or not the Department was correct in its determination of clinically necessary services for the Claimant under the I/DD Waiver Program.

V. APPLICABLE POLICY:

West Virginia Medicaid Provider Manual, Chapter 513 – I/DD Waiver Services, effective October 1, 2011

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 West Virginia Medicaid Provider Manual, Chapter 513 – I/DD Waiver Services, §513.9.1.8.1
D-2 West Virginia Medicaid Provider Manual, Chapter 513 – I/DD Waiver Services, §513.9.1.8.2
D-3 West Virginia Medicaid Provider Manual, Chapter 513 – I/DD Waiver Services, §513.9.1.12.1
D-4 West Virginia Medicaid Provider Manual, Chapter 513 – I/DD Waiver Services, §513.9.1.10.1
D-5 West Virginia Medicaid Provider Manual, Chapter 513 – I/DD Waiver Services, §513.9.1.1
D-6 Denial notice, dated December 12, 2011
D-7 Inventory for Client and Agency Planning assessment form, evaluation date September 14, 2011
D-8 Tentative schedule for ---- ----, dated November 18, 2011
D-9 Excerpt from *Examiner's Manual, Inventory for Client and Agency Planning*
D-10 Budget document for Claimant, service start dates of December 1, 2011
D-11 Budget document for Claimant, service start dates of December 1, 2010

VII. FINDINGS OF FACT:

1) The Claimant, who is a 27-year old recipient of I/DD Waiver Services, received notification of denial for a requested increase in services through the program (Exhibit D-6) on or about December 12, 2011. This notice provided the denial reason as "Your request to increase the amount of service was not determined to be clinically necessary and is denied." The notice further provides a table with service names and codes, and the requested and approvable amounts for each.

For *Person-Centered Support – Agency (1:1)* (hereinafter "PCS-A"), with a service code of S5125U1, 5408 units were requested on the Claimant's behalf.

For *Person-Centered Support – Family (1:1)* (hereinafter "PCS-F"), with a service code of S5125U5, 8784 units were requested on the Claimant's behalf.

For *Skilled Nursing – LPN (1:1)* (hereinafter "Nursing"), with a service code of T1003U4, 3328 units were requested on the Claimant's behalf.

For *Respite – Agency (1:1)* (hereinafter "Respite"), with a service code of T1005U1, 6656 units were requested on the Claimant's behalf.

For PCS-A, PCS-F, Nursing, and Respite, the Department determined a total of 17,520 units approvable.

For *Behavior Support Professional* (hereinafter "BSP"), with a service code of T2025, 800 units were requested on the Claimant's behalf and 700 units were determined approvable by the Department.

2) Pat Nisbet, representative for the Department, testified that the appropriate policy for this matter was the West Virginia Medicaid Provider Manual, Chapter 513 – I/DD Waiver Services, effective October 1, 2011. Ms. Nisbet presented excerpts from §513.9.1.1, §513.9.1.8.1, §513.9.1.8.2, §513.9.1.10.1, and §513.9.1.12.1 of this manual. It should be noted that the previous determination of services for the Claimant was under a different version of this manual, for the predecessor to the I/DD Waiver Program: the Waiver Program for Persons with Mental Retardation and Developmental Disabilities (hereinafter "MR/DD Waiver Program").

3) All manual sections cited by Ms. Nisbet correspond with the requested services in question, and all define a 'service unit' or 'unit' as equal to fifteen minutes. Testimony clarified that service units are quoted on an annual basis.

4) All sections except §513.9.1.1 state the following under the 'prior authorization' heading:

> 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.

At §513.9.1.1, a virtually identical 'prior authorization' statement is provided, as follows:

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

5) At §513.9.1.8.1 (Exhibit D-2), policy defines the PCS-A service as follows:

> Person-Centered Support (PCS) services consist of individually tailored training and/or support activities that enable the member to live and inclusively participate in the community in which the member resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence, personal choice and allow for maximum inclusion into their community.
>
> PCS services may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:
>
> - Self-care;
> - Receptive or expressive language;
> - Learning;
> - Mobility;
> - Self-direction; and
> - Capacity for Independent Living
>
> Agency staff administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent General Education Development (GED).
>
> PCS services may include member specific training. Attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the ASO is permitted if requested by the member or their legal representative.

6) At §513.9.1.8.2 (Exhibit D-2), policy defines the PCS-F service as follows:

> Person-Centered Support (PCS): Family consists of individually tailored training and/or support activities that enable the member to live and inclusively participate in the community in which the member resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence, personal choice and allow for maximum inclusion into their community. PCS: Family may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:
>
> - Self-care;

- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living

PCS: Family services must be assessment based and outlined on the member's IPP. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs.

PCS: Family services may include member specific training, attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the ASO.

Agency Staff providing PCS: Family must be a family member living in the member's home or a certified Specialized Family Care Provider providing this service in a certified Specialized Family Care Home. PCS: Family may not be provided to a member by the member's spouse.

7) At §513.9.1.12.1 (Exhibit D-3), policy defines Nursing services as follows:

Nursing services listed in the service plan are within the scope of West Virginia's Nurse Practice Act, ordered by a physician and are provided by a LPN under the supervision and monitoring of a RN actively licensed to practice in the State. Nursing services that must be provided by a LPN include but are not limited to: (Note: If these services are provided by an RN then the LPN code must be billed for reimbursement)

- Routine monitoring (data collection) of specific medical symptoms such as seizures, bowel habits, blood pressure, diet and exercise;
- Verifying and documenting physician orders if only RNs or LPNs are administering medication (no AMAPS are administering medications);
- Reviewing and verifying physician orders are current, properly documented and communicated to direct care staff and others per I/DD Waiver provider policy;
- Direct nursing care including medication/treatment administration;
- Review of Medication Administration Records (MARs), medication storage and documentation (when no AMAPs are administering medication);
- Review scheduled medical appointments before occurrence and communicate this information to others per I/DD Waiver provider policy;
- Facilitate procurement of and monitoring of medical equipment;
- Keep emergency contact information updated and accurate;

- Bill for travel time between ISS, licensed group home and licensed day program settings for the purpose of passing medications.

If a member requires more than two hours per day of LPN service, the Request for Nursing Service (WV-BMS-I/DD-09) must be submitted to the ASO for prior authorization.

If the member receives two or more hours of skilled nursing services per day, then the LPN is responsible for providing direct care supports and training.

In ISS or licensed group homes, the total number of service units may exceed 24 hours per day when the LPN also passes medication.

The LPN may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO at the request of the member or their legal representative.

8) At §513.9.1.10.1 (Exhibit D-4), policy defines Respite services as follows:

Respite: Agency services are specifically designed to provide temporary substitute care normally provided by a family member or a Specialized Family Care Provider. The services are to be used for relief of the primary care-giver(s) to help prevent the breakdown of the primary care-giver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Respite Services consist of temporary care services for an individual who cannot provide for all of their own needs.

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.

Agency staff providing Respite: Agency services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by ASO if requested by the member or their legal representative.

9) At §513.9.1.1 (Exhibit D-5), policy defines the BSP service as follows:

This service is provided to members with identified maladaptive behaviors and documented social behavior skill deficits documented through one of the following conditions:

- Member must currently exhibit maladaptive behaviors so severe that the adaptive functioning and ability to receive adaptive training is limited or impossible unless maladaptive behaviors are reduced or eliminated.
- Member may have a history of behaviors beyond one year that have resulted in severe life threatening situations such as fire setting or arson or sexual assault or offending behaviors that result in bodily harm to others or self.
- Member must have identified behaviors on the IPP that require tracking of behavioral data for the functional assessment.
- Member must have a functional assessment that outlines one or more specific target behaviors that are currently or will be addressed in a behavioral protocol or a positive behavior support plan.

The BSP is responsible to identify targeted maladaptive behaviors; develop hypotheses and Positive Behavior Support plans; develop habilitation plans and provide training in the person-specific aspects and method of a plan of intervention to the direct care staff (i.e. family, person-centered support workers, facility-based day habilitation workers, supportive employment providers, crisis workers and respite workers). The BSP also provides ----luation/monitoring of the effectiveness of the Positive Behavior Support plan through analysis of programming results.

I/DD Waiver provider agencies who submit their curriculum for approval to the West Virginia Positive Behavior Support (WV-PBS) Network may allow their agency staff who was formerly credentialed as Therapeutic Consultant Behavior Analysts or Therapeutic Consultant Behavior Specialists before October 1, 2011 to bill the BSP code as long as they meet all other requirements listed below. The WV-PBS Network approves all curriculums that meet the Association of Positive Behavior Support (PBS) standards of practice within six months of submission and the West Virginia I/DD Waiver provider completes training of agency staff within six months of approval of the curriculum. All curriculums submitted must include a minimum of 20 hours of training in APBS standards of practice and 10 hours of mentoring. This mentoring training is not member-specific and is not billable.

All newly hired agency staff must be either completely trained in a curriculum which has been approved by the WV-PBS Network or meet other requirements below before being allowed to bill the BSP code.

The Behavior Support Professional may perform the activities listed below.

- Take responsibility for all aspects of Positive Behavior Support services.
- Complete behavioral assessment or evaluation consisting of activities such as functional assessment of targeted behavior or analysis of behavioral data.
- Facilitate the development of Positive Behavior Support plans addressing behavioral protocols and behavioral guidelines.
- Train direct care staff to implement Positive Behavior Support plans.
- Develop behavioral protocols and behavioral guidelines for direct care staff or families.
- Develop methodology for intervention with the individual.
- Assess, evaluate and monitor the effectiveness of Positive Behavior Support plans.
- Develop adaptive habilitation plans based upon the member's assessed adaptive and maladaptive needs.
- Collaborate with Therapeutic Consultant(s) (when applicable) to ensure that positive behavior support strategies are consistently applied within all training strategies.
- Train direct care staff, model training strategies and observe staff to ensure that proper implementation of training strategies are imbedded across all aspects of habilitation. This may include training on members' health and safety needs as well as speech, physical and occupational therapy treatment activities.
- Facilitate person-centered planning as a component of the Positive Behavior Support Plan.
- Present proposed member's restrictive measures to the I/DD Waiver provider's Human Rights Committee if no other professional is presenting the same information.
- May attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO if requested by the member or their legal representative.

10) The Department presented a budget document (Exhibit D-11) showing approved services for the Claimant in the prior budget year.

PCS-A services were approved at a level of 936 units.

PCS-F services were approved at a level of 1464 units.

Nursing services (in two separate entries) were approved at a level of 2496 units.

Respite services (in two separate entries) were approved at a level of 6273 units.

BSP services were approved at a level of 160 units.

Services were approved under the following service names, in the following amounts: Agency Residential Habilitation – 4322 units, Behavior Specialist – Residential – 551 units, Community Residential Habilitation (in two separate entries) – 3642 units, Day Habilitation – 1551 units. This service name language carries over from the previous provider manual for the program.

11) The West Virginia Medicaid Provider Manual, Chapter 513: MR/DD Waiver Services (predecessor to the I/DD Waiver Program), effective November 1, 2007, defines Agency Residential Habilitation at §513.7.6.2, as follows:

> Agency Residential Habilitation services are support services delivered in a participant's residence and in the member's community which provide instruction and assistance to enable him/her to acquire and maintain skills which will allow him/her to live and socialize more independently. Residential Habilitation services may also include behavioral support to reduce challenging behaviors and replace them with socially valuable, adaptive behaviors and skills. Training must be age appropriate, functional and natural in terms of materials, location and times.

At §513.7.11.2, this policy defines Behavioral Specialist as follows:

> Behavioral Specialist provides training in the person-specific aspects and method of a plan of intervention or instruction to the primary care providers (i.e., family, residential habilitation providers, day habilitation providers, prevocational providers, supportive employment providers) for members with significant maladaptive behaviors. The plan of intervention will require a behavioral guideline, protocol, or plan dependent on the member's need. The Therapeutic Consultant also provides evaluation/monitoring of the effectiveness of the plan of intervention or instruction.

At §513.7.6.1, this policy defines Community Residential Habilitation as follows:

> Community Residential Habilitation services are support services delivered in a participant's residence and in the community which provide instruction and assistance to enable him/her to acquire and maintain skills which will allow him/her to live and socialize more independently. Residential Habilitation services may also include behavioral support to reduce challenging behaviors and replace them with socially valuable, adaptive behaviors and skills. Training must be age appropriate, functional and natural in terms of materials, location and times.

At §513.7.8, this policy defines Day Habilitation as follows:

Day Habilitation is a structured program that is designed to promote the acquisition of skills or maintenance of skills for the member outside the residential home. Day Habilitation activities must occur during naturally occurring routines of the day for the member.

Day Habilitation activities in the plan must be developed exclusively to address the habilitation needs of the member. Activities should not be integrated to occur concurrently with personal or work activities of a staff member or family members. This includes such activities such as socialization, shopping, transporting or delivery needs of the staff member.

Day Habilitation services must be based on assessment, be person-centered/goal oriented, and with meaningful/productive activities that are guided by the member's needs wishes, desires, and goals.

12) There was no clinical documentation submitted on the Claimant's behalf supporting the need for an increase in I/DD Waiver services. The Claimant's mother testified that the request was not for an increase in services, but for services to continue at the previous level. The Claimant's mother testified regarding the need for help transferring her daughter and regarding the medical reasons the Claimant must be repositioned in bed at night.

13) Nora Oscanyan, a witness for the Department and employee of APS Healthcare (a firm contracted to manage aspects of the I/DD Waiver Program for the Department), testified that there was no Behavior Support Plan submitted on the Claimant's behalf to support the need for additional BSP services. Jennifer Evan, witness for the Department and employee of APS Healthcare, testified that when such a plan is not received, the basis for a decision regarding a request for increased services is the Inventory for Client and Agency Planning (hereinafter "ICAP").

14) Referring to the ICAP for the Claimant (Exhibit D-7), Ms. Eva noted that under the section headed 'Problem Behaviors' the frequency of such behaviors for the Claimant is listed as 'Never' for the categories of 'Hurts Self,' 'Hurts Others,' and 'Destructive.'

Under the 'Maladaptive Behavior Index Scores' section, the general score for the Claimant is -19. The historical summary lists the same score for the Claimant in 2010 and 2009. To put this score in context, Ms. Eva referred to an excerpt from *Examiner's Manual, Inventory for Client and Agency Planning* (Exhibit D-9), including the following list:

Index Value	**Level of Seriousness**
+10 to -10	N = normal
-11 to -20	MgS = marginally serious
-21 to -30	MdS = moderately serious

-31 to -40	S = serious
-41 and below	VS = very serious

She testified that this score places the Claimant in the category of 'marginally serious' and that a score change to the 'moderately serious' category, or greater frequency of problem behaviors could have demonstrated the need for additional BSP services; however, the ICAP as reviewed did not reveal any such need.

15) Ms. Oscanyan testified that the Claimant has an assigned budget of $94,524.92. She testified that the budget document (Exhibit D-10) that shows this amount also shows the $132,873.20 cost of services the Claimant receives while in hearing status, which represents maintenance of services at the previous level. She testified that the Claimant's requested services, if approved, would result in an actual budget for the Claimant that exceeds her assigned budget by $47,516.92. Exhibit D-10 contains a section headed 'over budget justification' which states "Budget reflects client's needs."

VIII. CONCLUSIONS OF LAW:

1) Policy for the I/DD Waiver Program states that before services may be provided, a prior authorization process must be completed. Services approved are based on the assessed need of the program recipient, and in consideration of their individualized budget. Testimony and evidence revealed that the actual budget ($132,873.20) for the Claimant exceeds her assigned budget ($94,524.92), and the proposed budget (i.e., the budget for all services requested on the Claimant's behalf). The proposed budget exceeds the assigned budget by a greater amount ($47,516.92 versus $38,348.28), but there was no reason given that the Department's documented justification for exceeding budget by $38,348.28 – that the budget reflects the Claimant's needs – would not be valid justification for exceeding budget by $47,516.92. As such, the services requested on the Claimant's behalf cannot be denied solely due to budget considerations.

2) The Claimant received I/DD Waiver services through a transition of the program from its predecessor (the MR/DD Waiver Program). Nomenclature and coding of services changed in this transition; however, it is critical to consider services received under the previous program – and their equivalents in the new program – to determine if services requested on the Claimant's behalf and proposed by the Department constitute an increase or decrease in services (requiring documentation of a corresponding increase or decrease in assessed need).

3) The Department issued a notice to the Claimant denying their requested units of service for five different service types. In this notice, and in Department testimony, it was indicated that 'approvable units' reflected what the Department would be 'willing to approve.' These amounts will be treated as a proposed service level by the Department – or, the default level of services had the Claimant not maintained her prior service level through the hearing process.

4) The Department bundled together four requested service categories – PCS-A, PCS-F, Nursing, and Respite – and proposed a combined level of 17,520 units for all of these services. The Claimant requested a combined level of 24,176 units for these four services (5408 units of PCS-A, 8784 units of PCS-F, 3328 units of Nursing, and 6656 units of Respite). The level of services received by the Claimant in the prior budget year must be determined to establish proposed levels as increases or decreases.

5) Present I/DD Waiver policy defines both PCS-A and PCS-F as services intended to provide training and support to help a program recipient increase the acquisition of skills and behavior necessary to live and participate in their residence and community independently, inclusively, and with greater choice; they differ in that PCS-F services must be administered by family or a certified Specialized Family Care Provider. Prior MR/DD Waiver policy defines both Agency Residential Habilitation and Community Residential Habilitation as support services in the program recipient's home or community consisting of instruction or assistance with the acquisition or maintenance of skills necessary to live and socialize more independently. The Day Habilitation service is defined by prior MR/DD Waiver policy as a program intended to help the program recipient acquire or maintain such skills outside the home. The definitions for Agency Residential Habilitation, Community Residential Habilitation, and Day Habilitation services from the MR/DD Waiver Program are equivalent to the broader definitions for PCS-A and PCS-F services (again, with PCS-A and PCS-F only distinguished by the staff providing the service) under the I/DD Waiver Program. Units previously approved for the Claimant for Agency Residential Habilitation (4322 units), Community Residential Habilitation (3642 units), and Day Habilitation (1551 units) services must be included in the sum of services previously received by the Claimant. Therefore, the budget document for the Claimant reflects a total of services under current service names (PCS-A of 936 units, PCS-F of 1464 units, Nursing of 2496 units, and Respite of 6273 units) and previous service names (9515 units) of 20,684 units for the four service categories bundled together by the Department.

6) The Claimant's request for 24,176 units in the four bundled categories is greater than 20,684 units, and constitutes a requested increase in services. The Department's proposal of 17,520 units in the four bundled categories is less than 20,684 units, and constitutes a proposed reduction in services to the Claimant.

7) In the four bundled categories (PCS-A, PCS-F, Nursing, and Respite) no evidence or testimony regarding a change in the clinical needs of the Claimant was presented. The Claimant's mother testified regarding her need for assistance repositioning and transferring the Claimant, but did not testify that this need had increased. The Department was correct to deny a requested increase in services without a corresponding increase in assessed need. The Department was incorrect to propose a decrease in services to the Claimant without documentation of a reduction in assessed need. Services in these four current categories (PCS-A, PCS-F, Nursing, and Respite) must be maintained at 20,684 units – the sum of the units previously approved for current services and their legacy equivalents.

8) Present I/DD Waiver policy defines the BSP service as indentifying maladaptive behaviors by the program recipient and the development, training, evaluation, and monitoring of a behavior support plan to address those maladaptive behaviors. Prior MR/DD Waiver policy defines a Behavior Specialist as an individual responsible for training on a plan of intervention or instruction to primary care providers for program recipients with significant maladaptive behaviors. The definitions are equivalent, and the 160 units approved for the Claimant under the BSP category must be included with the 551 units approved for the Claimant under the previous Behavior Specialist category, for a total of 711 units. Based on this total, the Claimant's request of 800 units constitutes a requested increase and the Department's proposal of 700 units constitutes a proposed decrease in services to the Claimant.

9) There was no testimony or evidence documenting an increase or decrease in the maladaptive behavior of the Claimant – the basis for assessed need for BSP services. The Department presented test scores from an instrument used to measure such behavior that assessed the Claimant at the same level for the last three years. The Department is correct to deny the Claimant's request for an increase in BSP services without justification based on an increase in clinical need. The Department is incorrect to propose a reduction in the Claimant's services without justification based on a decrease in clinical need. BSP services must be maintained at the level of 711 units.

IX. DECISION:

It is the decision of the State Hearing Officer to **uphold** the decision of the Department to deny a requested increase in services offered through the I/DD Waiver Program. It is additionally the decision of the State Hearing Officer to **reverse** any proposal of the Department to reduce the following I/DD Waiver Program services from the respective annual units listed: Person-Centered Support – Agency, Person-Centered Support – Family, Skilled Nursing – Licensed Practical Nurse, and Respite (a total of 20,684 units for these four categories, to be allocated at Claimant's discretion); Behavior Support Professional (711 units).

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this _____ Day of April, 2012.

Todd Thornton
State Hearing Officer