



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

May 10, 2012

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Dear -----:

Attached is a copy of the Findings of Fact and Conclusions of Law for ----- hearing held February 29, 2012. The hearing request was based on the Department of Health and Human Resources' denial of requested Respite 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 the requested service 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; §513.9.1.10.1).

Information and testimony submitted at the hearing established the Department's denial was not based on budget considerations, but instead on clinical need. For this reason, clinical need cannot be discounted for budgetary reasons. Information and testimony submitted at the hearing established justification for a one-to-one (1:1) ratio in respite services. Based on this, the undiscounted level of 6,912 annual units of respite requested is approvable at the 1:1 ratio.

It is the decision of the State Hearing Officer to **reverse** the Department's denial of a request for 6,912 annual units of Respite services, at a 1:1 ratio, through the I/DD Waiver Program.

Sincerely,

Todd Thornton  
State Hearing Officer  
Member, State Board of Review

cc: Erika H. Young, Chairman, Board of Review  
[REDACTED] West Virginia Advocates  
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-334**

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

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

All participants offering testimony in the hearing were placed under oath.

**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, §513.9.1.10.1
- D-2 Denial notice dated December 12, 2011
- D-3 Budget document for Claimant, service start dates of December 1, 2011
- D-4 Letter dated December 7, 2011
- D-5 Letter dated January 3, 2012

**VII. FINDINGS OF FACT:**

- 1) The Claimant, who is a 48-year old recipient of I/DD Waiver Services, received notification of denial for requested services through the program (Exhibit D-2) on or about December 12, 2011. This notice provided the denial reason as “Your request is not determined to be clinically necessary.” The notice specified the Claimant’s request as 6912 units of *Respite – Agency (1:1)*, with a service code of T1005U1. Under the heading “Approvable Units,” the notice states:

Up to 4,380 units per service year of T1005U1 or up to 6,912 of Respite-Agency (1:2) T1005U5 due to two members living in the home

- 2) The Department presented the appropriate policy for this matter (Exhibit D-1) from the West Virginia Medicaid Provider Manual, Chapter 513 – I/DD Waiver Services, effective October 1, 2011. At §513.9.1.10.1, this policy addresses Respite services as follows:

**513.9.1.10.1 Respite: Agency: Traditional Option**

**Procedure Code:** T1005-U1 1:1 ratio  
T1005-U5 1:2 ratio  
T1005-U6 1:3 ratio

**Service Units:** Unit = 15 minutes

**Prior Authorization:** 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.

**Site of Service:** This service may be provided in the member’s family residence, a Specialized Family Care Home, a licensed day program facility and public community locations. When this service is provided in a home setting other than the member’s, the home setting must be a certified Specialized Family Care Home.

**Definition of Service:**

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.

**Documentation:**

Documentation must be completed on the Direct Care Service Log (WV-BMS-I/DD-07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues the agency staff should complete the accompanying Direct Care Progress Note to detail the issue. The Direct Care Service Log must include all of the following items.

- Member's Name
- Service Coordination Provider Name
- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate staff to member ratio
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the agency staff

**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.
- Respite: Agency services are not available to members living in ISS or licensed group home settings.

- Respite: Agency services are not to replace natural supports available to the member.
- Respite: Agency services may not be provided by an individual living in the member's own or family residence in which the member resides or within the Specialized Family Care Home where the member resides.
- Respite: Agency is not available in medical hospitals, nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.
- Up to 48 units/12hours of Respite services every three months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to staff providing Respite: Agency Services.
- Respite: Agency Services may not be provided in an ICF/MR facility,
- 6,912 units/1,728 hours per year (averages out to 144 hours/month or 4.73 hours/day) per member's annual IPP year.
- This service may not be billed concurrently with any other direct care service.
- Agency staff to member ratios for this service are 1:1, 1:2, and 1:3.
- Only 1:1 or 1:2 ratios are allowed to be utilized in a member's family residence or in a Specialized Family Care Home.

**Agency Staff Qualifications:**

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

- 3) The Department presented a budget document (Exhibit D-3) showing approved services for the Claimant. Proposals for Respite services were not included in the totals. The assigned budget for the Claimant in the budget year from December 1, 2011 through November 30, 2012 is \$61,592.38, and the total cost of displayed services is \$58,811.08, leaving a remaining budget amount of \$2,781.30. Department testimony clarified that not only would the Claimant's requested Respite services put the Claimant over her assigned budget, so would the two alternatives proposed by the Department as "approvable units."

- 4) When asked for clarification regarding the Department proposals that would still result in a total cost of services in excess of the Claimant's budget, Jennifer Eva, a representative for the Department employed by APS Healthcare – an agency that assists the Department in the administration of I/DD Waiver Services – responded that the decision to deny the Claimant's request was not based on budgetary considerations but instead on the demonstrated clinical need of the Claimant; she noted that what the Department was willing to approve would put the Claimant over her assigned budget.
- 5) Patricia Nisbet, a representative for the Department's Bureau for Medical Services, presented a letter (Exhibit D-4), dated December 7, 2011, from -----of PAIS, Inc. – a service provider of I/DD Waiver Services to the Claimant – noting the following excerpt from a section regarding Supported Employment units:

This client is an employee at ----- and works from 8:00am-2:00pm, Monday through Friday...

Ms. Nisbet opined that because the Claimant works thirty hours per week, the caregivers for the Claimant have “a break” that must be factored into the Department's determination of Respite need. Ms. Nisbet testified that “...we didn't feel that she needed 4.73 hours a day of Respite on top of that; we thought that 3 hours a day would be sufficient.”

(Services can be expressed in terms of units per service year or hours per day. Annual units of 6,912 and 4,380 may be converted to hours per day of 4.73 and 3, respectively, by dividing by 4 units per hour and 365 days per year – or simply 1,460.)

-----, conservator for the Claimant, testified that the Claimant works twenty-eight hours per week instead of thirty. She noted that the other I/DD Waiver recipient in the home is only out of her care – receiving other services – for three hours per day, and then only when a worker can be found to address the behavioral problems of the other recipient. She testified that frequently she does not have such a worker, so ----- does not receive the equivalent of Respite services while the Claimant is out of the home receiving Supported Employment services.

- 6) The same letter (Exhibit D-4) directly addresses the Respite needs of the Claimant as follows, in pertinent part:

Respite services for this natural family were requested as such because there are two I/DD participants that reside in the home, thus requiring twice the care & oversight from the care givers/guardians. Such services affords care givers/guardians the opportunity for weekly reprieve to tend to personal/business matters as needed.

- 7) -----, representative for the Claimant, contended that the Claimant requires Respite services at a 1:1 ratio of service worker to member; to force the Claimant to share services at a 1:2 ratio with the other I/DD Waiver Services recipient in the home would ignore the individualized needs of the Claimant and the other recipient in the home.
- 8) Testimony on the Claimant's behalf described her as preferring to be out of the home for Respite activities, while the other recipient would prefer to be at home playing. The Claimant was described as not having the severe behavioral problems of the other I/DD Waiver recipient in the home. The Claimant was described as sometimes "aggravated" by the noises and behaviors of the other recipient in the home. The Respite staff member assigned to the Claimant is male, has established a good working relationship with the Claimant, and has worked with the Claimant since 2003. Because the other recipient in the home suffers from Post-traumatic Stress Disorder as a result of past sexual assault, she is unable to have a male worker; the Claimant would be forced to change her Respite worker to receive Respite services at the 1:2 ratio.

#### **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, if approved, either the level of Respite services requested by the Claimant or the two proposed levels by the Department would result in the Claimant's total cost of services exceeding her assigned budget for the program. Testimony from the Department confirmed that the decision to deny the Claimant's request was not based on her budget, but instead on her assessed need. As such, the services requested by the Claimant cannot be denied solely due to budget considerations.
- 2) The Department contended that because the Claimant receives Supported Employment services and is out of the home working for thirty hours per week, this time reduces the need for Respite services. The Department representative testified that this factor reduced the Claimant's need for Respite services from 4.73 hours per day (equivalent to 6,912 units per service year) to 3 hours per day (4,380 units per service year); however, the Department's denial notice included "approvable units" of 6,912. The only difference between the 6,912 units requested by the Claimant and considered "approvable" by the Department is the underlying ratio of service – a 1:1 ratio requested by the Claimant and a 1:2 ratio proposed by the Department. The different ratios result in two different outcomes for cost and care; the Department emphasized that this decision was based on assessed need and not cost, and as such, the correctness of the Department's decision depends on the correctness of its assessment of the Claimant's necessary units of care and necessary ratio of services.



- 3) The Department issued a letter to the Claimant, denying her request for Respite services. In this denial letter, the Department responds with two proposed service levels under the heading “approvable units.” A determination of clinical need cannot have two outcomes. Clinical need for a service is expressed in units of time, budgets are expressed in terms of dollars, and the two may not necessarily correspond. For the Department to propose 6,912 units of Respite services for the Claimant but only offer 4,380 units at the Claimant’s requested ratio (1:1 instead of 1:2) is to discount clinical need in favor of budgetary considerations. The Claimant’s clinical need is established as 6,912 units per year of Respite services – based on the Department’s own determination.
  
- 4) The appropriate ratio of Respite services in this case comes into consideration because the Claimant resides with another individual receiving I/DD Waiver Services. Testimony on the Claimant’s behalf clearly established a need for her to continue to receive Respite services at a 1:1 ratio. Switching to a 1:2 ratio would force the Claimant to change her Respite-time activities and Respite staff to match the needs of the other I/DD Waiver Services recipient in the home. For these reasons, the appropriate ratio of Respite services to the Claimant is 1:1.
  
- 5) The clinical need of the Claimant is established as 6912 units per year of Respite services, and the appropriate ratio of services is established as 1:1. The Claimant’s request has been documented as clinically necessary, and the Department was incorrect to deny the request.

**IX. DECISION:**

It is the decision of the State Hearing Officer to **reverse** the decision of the Department to deny the Claimant’s request for services offered through the I/DD Waiver Program – specifically, Respite – Agency (1:1) services, coded T1005U1, in the amount of 6,912 units per service year.

**X. RIGHT OF APPEAL:**

See Attachment

**XI. ATTACHMENTS:**

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

**ENTERED this \_\_\_\_ Day of May, 2012.**

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**Todd Thornton  
State Hearing Officer**