STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW
Raleigh County District
407 Neville Street
Beckley, WV 25801

Bill J. Crouch
Cabinet Secretary

Jolynn Marra
Interim Inspector General

February 3, 2021

RE: v. WV DHHR
ACTION NO.: 21-BOR-1003

Dear Ms. :

Enclosed is a copy of the decision resulting from the hearing held in the above-referenced matter.

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.

You will find attached an explanation of possible actions you may take if you disagree with the decision reached in this matter.

Sincerely,

Kristi Logan
Certified State Hearing Officer
Member, State Board of Review

Encl: Appellant's Recourse to Hearing Decision
Form IG-BR-29

cc: Bureau for Medical Services, KEPRO

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

,

Appellant,

v. **Action Number: 21-BOR-1003**

WEST VIRGINIA DEPARTMENT OF
HEALTH AND HUMAN RESOURCES,

Respondent.

DECISION OF STATE HEARING OFFICER

INTRODUCTION

This is the decision of the State Hearing Officer resulting from a fair hearing for . This hearing was held in accordance with the provisions found in Chapter 700 of the West Virginia Department of Health and Human Resources' Common Chapters Manual. This fair hearing was convened on January 26, 2021, on an appeal filed December 30, 2020.

The matter before the Hearing Officer arises from the December 14, 2020, decision by the Respondent to deny the requested units of Service Coordination, Physical Therapy and Transportation Miles in excess of the Appellant's annual I/DD Waiver Program budget.

At the hearing, the Respondent appeared by Stacy Broce, I/DD Waiver Interim Program Manager with the Bureau for Medical Services. Appearing as a witness for the Respondent was Ashley Quinn, I/DD Waiver Program Educator with KEPRO. The Appellant appeared *pro se*. Appearing as witnesses for the Appellant were , Service Coordinator with , , RN with , with and , Advocate with Disability Rights of West Virginia. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Notice of Denial dated December 14, 2020
D-2 Bureau for Medical Services Provider Manual §513.19
D-3 Bureau for Medical Services Provider Manual §513.12.3
D-4 Bureau for Medical Services Provider Manual §513.21.1
D-5 Bureau for Medical Services Provider Manual §513.25.4.2
D-6 Bureau for Medical Services Provider Manual §513.8.1

D-7 Bureau for Medical Services Provider Manual §513.28
D-8 Bureau for Medical Services Provider Manual §513.25.2
D-9 I/DD Waiver Exceptions Request Form Request for Services Above the Budget dated November 9, 2020
D-10 I/DD Waiver Exceptions Request Form Request for Services Above the Budget dated November 9, 2020, Attachment 1
D-11 I/DD Waiver Exceptions Request Form Request for Services Above the Budget dated November 9, 2020, Attachment 2
D-12 Budget Approval Letter dated September 16, 2020
D-13 Individualized Program Plan, November 2020-October 2021
D-14 Crisis Plan updated April 16, 2020
D-15 Request for Nursing Services dated October 28, 2020
D-16 Request for Nursing Services dated November 9, 2020
D-17 I/DD Waiver Structured Interview dated August 18, 2020
D-18 Purchase Request Details Screen Print for Service Year November 2020-October 2021
D-19 Inventory for Client and Agency Planning dated August 18, 2020
D-20 Respondent Rights and Responsibilities signed August 18, 2020

Appellant's Exhibits:

A-1 Correspondence from [redacted], Physical Therapist, dated January 15, 2021
A-2 Individualized Program Plan Billing for Service Year November 2019-October 2020

After a review of the record, including testimony, exhibits, and stipulations admitted into evidence at the hearing, and after assessing the credibility of all witnesses and weighing the evidence in consideration of the same, the Hearing Officer sets forth the following Findings of Fact.

FINDINGS OF FACT

1) The Appellant is a participant in the I/DD Waiver Program.

2) The Appellant's annual budget for I/DD Waiver services for November 2020 - October 2021 was calculated as $213,817 (Exhibit D-12).

3) An Exceptions Request was submitted on behalf of the Appellant on November 9, 2020, requesting additional Service Coordination, Physical Therapy and Transportation Miles units in excess of the Appellant's assigned I/DD Waiver budget (Exhibit D-11).

4) The Appellant requested 540 units of Service Coordination, 240 units of Physical Therapy and 6,000 units of Transportation Miles. The approval of the additional units would exceed the Appellant's approved budget by $11,439.60 (Exhibit D-11).

5) The Respondent approved 240 units of Service Coordination, 12 units of Physical Therapy and 478 units of Transportation Miles (Exhibit D-1).

6) The Respondent issued a Notice of Denial on December 14, 2020, advising the Appellant that the request for additional units of Service Coordination, Physical Therapy and Transportation Miles had been denied as the services that could be purchased within the budget were insufficient to prevent a risk of institutionalization (Exhibit D-1).

APPLICABLE POLICY

Bureau for Medical Services Provider Manual §513.25.4.2 describes the process in determining a participant's I/DD Waiver Program budget.

Service Authorization Process
The Utilization Management Contractor (UMC) will conduct the functional assessment up to 90 days prior to each person's anchor date. If determined medically eligible, the person or their legal representative and Service Coordination provider will receive an individualized budget calculated pursuant to the methodology described below. Once the person's budget has been calculated, the person will receive a notice each year that sets forth the person's individualized budget for the Individualized Program Plan (IPP) year and an explanation for how the individualized budget was calculated. The UMC, the person, the legal representative, the service coordinator, and any other members of the Interdisciplinary Team (IDT) that the member wishes to be present will attend the annual assessment. The UMC will work with the person and his or her team to complete three forms: the Inventory for Client and Agency Planning (ICAP), the Adaptive Behavior Assessment System II (ABAS II) and the Structured Interview.

The person and/or his legal representative shall sign an acknowledgment that they participated in the assessment and were given the opportunity to review and concur with the answers recorded during the assessment. If the person or his legal representative declines to sign the acknowledgment for any reason (e.g., he or she does not believe the answers were recorded accurately), the person or their legal representative shall notify the UMC through their service coordinator within 5 days of the assessment date, and the UMC shall resolve the issue by conferring with the person and/or the legal representative to come to an agreement on the answers on the assessment. If the person or their legal representative still disputes the answers on the assessment, then the issue can be appealed through a Medicaid Fair Hearing.

Budget Methodology
Once the assessment is complete, the person's budget is developed pursuant to Bureau for Medical Services') BMS's budget methodology.

Effective for people with anchor dates starting on July 1, 2018, budgets will be calculated pursuant to the methodology described in this Section. Under this methodology, a person's individualized budget is based on two components: 1) a "base" budget range that is determined based on the person's setting, and 2) "add-on" funding that is determined based on answers relating to the person's functionality provided to the UMC on the most current ICAP. Any add-on amounts that the person qualifies for will be added to the person's base budget range, resulting in the person's final individualized budget for the IPP year. A person may request services that cost up to the top of their individualized budget range, but may not use services costing above their individualized

budget range, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in this section.

The table below describes the base budget ranges and add-on amounts for individuals receiving services for IPP years beginning July 1, 2018 and later. The base budget ranges and add-on amounts will be updated periodically.

Adult: Individual Support Setting 1 Person $176, 731 - $182,507

A person will receive additional funding through add-on(s) based on responses collected in the most current ICAP assessment, which is completed by the UMC at the annual assessment. The add-on corresponds to the following results on the ICAP:

Add-Ons Variable	**Add-On Amount**
Externalized Problem Behavior	
Extremely or very serious	$4,287
Moderately serious or slightly serious	$2,968
Asocial Problem Behavior	
Extremely or very serious	$3,840
Adaptive Behavior: Motor Skills (0-4)	
Motor skills Level 1	$1,459
Motor skills Level 2	$2,918
Motor skills Level 3	$4,377
Motor skills Level 4	$5,836
Adaptive Behavior: Personal Living Skills (0-4)	
Living skills Level 1	$1,233
Living skills Level 2	$2,466
Living skills Level 3	$3,699
Living skills Level 4	$4,932

The total maximum add-on to each base budget is $18,895.

The person will receive notice of his or her budget calculation, which will include an explanation for how the budget was calculated and instructions for seeking services that cost in excess of the budget. The budget calculation is not a decision about the services the person will be eligible to receive.

The IDT must initially make every effort to purchase services for the person receiving services ("person") within the budget allocated by the UMC. As part of this effort, the IDT should consider, among other things, substituting less expensive services for more expensive services; accessing Medicaid services offered outside of the IDDW program; and determining whether any services covered by private insurance may be helpful to the person.

Once the person receives his or her budget letter, the IDT team will meet with the person to develop the annual IPP. If the person and/or the IDT team develop an IPP that is within budget and otherwise compliant with DHHR policies (e.g., all services are within the service-specific caps), DHHR or their designated UMC will approve the IPP and authorize services consistent with the IPP.

Exceptions Request

The IDT has an obligation to make every attempt to purchase services it deems necessary within the individualized budget. If the IDT determines after careful consideration that funds beyond the individualized budget are still necessary to avoid a risk of institutionalization, the person and/or the legal representative (or the Service Coordinator on their behalf), after consultation with the IDT, may submit a request for services in excess of the budget to BMS through the UMC web portal, along with any supporting documentation.

If the person or his or her legal representative believes services in excess of the budget are necessary, they will fill out an additional section of the IPP that reflects all the additional services that person or his or her legal representative believes the person needs. Even if the IDT believes that services in excess of the budget are necessary, the IDT must complete the primary section of the IPP and specify services that can be purchased within the person's individualized budget. No services for the IPP year will be authorized unless this primary section is completed. The person or their legal representative must sign off on the request for services in excess of the budget. Services requested in excess of the budget, described in the additional section of the IPP, cannot be authorized unless and until an exception is approved through the exceptions process.

An "exceptions process" request for services exceeding the person's individualized budget is clinically researched and reviewed by BMS. Such request may also be negotiated between the person or their legal representative, the Service Coordinator/IDT and BMS. A panel of three individuals employed by DHHR or its contractor will review the "exceptions" request to determine if any errors were made in the service authorization process, including if any technical errors were made in the assessment, and/or if funds in excess of the budget are needed to purchase clinically appropriate services necessary to prevent a risk of institutionalization. At least one individual on the panel will have medical training. A decision will be made by the Exceptions Panel within 20 business days after the Exceptions Panel has received submission explaining the basis for the exceptions request with any/all supporting documentation.

The individual seeking additional services through the "exceptions process" has the burden of showing that services in excess of the individualized budget are necessary to avoid a risk of institutionalization. To make this showing, the person or his legal representative must provide a clear explanation on the "exceptions process" request as to which additional services are requested and why they are necessary to prevent a risk of institutionalization, and may provide documentation to support his or her position. All documentation must be attached/enclosed/provided if the person would like BMS to consider such documents in making its decision during the "exceptions process." Referring to documents on the "exceptions process" form is NOT sufficient; any documents the person would like BMS to consider must be attached to the "exceptions process" form and specific sections highlighted for BMS to review.

In determining whether the person has met his or her burden to receive services in excess of the budget, the three-person panel shall consider, among other things:

- The person's most recent ICAP, Structured Interview, and all IPPs from the current year.
- Any information provided by the person in his or her application for an exception.
- The feasibility of rearranging services within the person's budget.
- The availability of less expensive services that can be substituted for more expensive services.
- The availability of services covered outside the IDDW program by Medicaid or by private insurance.
- The natural supports (if any) available to the person, and limitations on those supports.

If BMS concludes that the person has demonstrated that funds in excess of the individualized budget are necessary to prevent a risk of institutionalization, BMS will authorize funds in excess of the budget to the extent necessary to keep the person safe and healthy and avoid a risk of institutionalization, and the IPP will be finalized. If BMS determines that the person did not demonstrate that funds in excess of the individualized budget are necessary to avoid a risk of institutionalization, BMS will not authorize funds in excess of the budget. If BMS determines that an error was made in the service authorization process, it will take the steps necessary to correct the
error.

If during the "exceptions process", BMS determines there was not an error, or that the requested additional services and funding are not warranted, a Letter of Denial will be sent to the person or their legal representative, which will include an explanation as to why the services(s) and funding were denied, how to file for a Medicaid Fair Hearing and free legal services available. All decisions during the "exceptions process" shall be reviewed and/or issued by BMS.

DISCUSSION

Pursuant to the policy, an I/DD Waiver participant's annual budget is based upon the Inventory for Client and Agency Planning (ICAP), the Adaptive Behavior Assessment System II (ABAS II) and the Structured Interview. A base budget amount is determined by the participant's living arrangement and additional funding, or "add-on" funding, is determined based on answers relating to the person's functionality from the most current ICAP. If services cannot be purchased within the participant's annual budget, the policy allows for the submission of an Exceptions Request to determine if services in excess of the assigned budget are necessary to prevent institutionalization of the I/DD Waiver participant.

The Respondent calculated the Appellant's annual budget for service year November 2020-October 2021 as $213,817, which included add-on funding based upon the Appellant's ICAP scores related to motor skills, externalized problem behaviors, asocial problem behaviors, and personal living skills. An Exceptions Request was submitted to the Respondent for additional units of Service Coordination, Physical Therapy and Transportation Miles exceeding the Appellant's budget. The Respondent denied this request, citing that the services available within the Appellant's budget were sufficient to prevent institutionalization.

The issue of the additional units of Service Coordination was no longer an issue as of the hearing due to the proposed change in billing from fifteen (15) minute increments to a monthly billing unit that will take effect in April 2021. The Appellant's representatives felt that due to the change in billing, the Appellant's budget could accommodate Service Coordination.

, Service Coordinator for the Appellant, testified that the Interdisciplinary Team made every effort to purchase services within the Appellant's budget to allow for the additional units of Physical Therapy and Transportation Miles, without decreasing Behavioral Support and Nursing services that are necessary to keep the Appellant in the community. Mr. contended that the Appellant's Exceptions Request for the previous service year was approved, for a total budget of $218,261.20. Mr. argued that the Appellant's ICAP score for the current service year is 15, a decrease from the previous year's score of 21, and yet the Exceptions Request for additional services was not approved. Mr. stated the Appellant's physician has ordered Physical Therapy twice weekly for 45 minutes each visit. Mr. testified it is imperative that the Appellant attend each therapy visit as ordered to treat osteoarthritis in the Appellant's knees to keep her mobile and prevent hospitalization. Mr. stated Medicaid will authorize approximately 66 units of Physical Therapy and additional units through the I/DD Waiver Program is necessary to accommodate the Appellant's Physical Therapy schedule.

, RN with , testified that the Appellant has experienced severe degenerative changes in her knees, and Physical Therapy is now addressing arthritis in the Appellant's lumbar spine. Ms. stated the Appellant's mobility has declined and attending Physical Therapy twice weekly is vital to keep her ambulatory. Ms. stated the Appellant performs better attending her therapy visits compared to completing exercises at home. Mr. noted that during the spring of 2020 COVID-19 lockdown, the Appellant was unable to attend her Physical Therapy appointments, affecting her mobility.

The Respondent testified that the services purchased in previous years was taken into consideration in the denial of the Exceptions Request. For the service year 2018-2019, only $207,000 was used of the Appellant's approved budget and for the service year 2017-2018, only $171,000 of the Appellant's budget was utilized. For the previous service year of 2019-2020, the Respondent stated there was money left in the Appellant's budget to purchase services. Although the Appellant is ordered to attend Physical Therapy for 45 minutes twice a week, several times only 30 minutes per visit was billed. The Respondent referred to the Appellant's annual assessment which indicated that the Appellant has had improvement with her mobility, rather than a decline, and there was no documentation submitted with the Exceptions Request noting a change in her condition as reference by Ms. The Appellant was allotted money to her base budget through add-ons due to her mobility rating.

The Appellant's witnesses testified that the Appellant is often unable to complete 45 minutes of Physical Therapy due to pain or non-compliance, therefore only 30 minutes of therapy is billed. Testimony from the Appellant's witnesses indicated that the amount of Transportation Miles requested was important to keep the Appellant socialized and participating in community activities.

The Appellant and her representatives have the burden of proof to demonstrate that services requested in excess of the approved annual budget are required to prevent institutionalization. There was no documentation submitted to support the claim that the Appellant has experienced degenerative changes in her knees, or that Physical Therapy was addressing arthritis in the lumbar spine. The Appellant's assessments documented an increase in her mobility, despite the months in which the Appellant was unable to attend Physical Therapy appointments due to COVID-19 restrictions. Without documentation to confirm a change in the Appellant's mobility, Physical Therapy services exceeding the annual budget cannot be approved.

The testimony provided regarding the need for Transportation Miles exceeding the budget failed to demonstrate that the Appellant would be at risk of institutionalization were they not approved. While testimony indicated the Appellant enjoyed planned outings within her community, there was no information provided to confirm the additional units would prevent the institutionalization of the Appellant.

The Respondent's denial of the requested units of Physical Therapy and Transportation Miles exceeding the Appellant's approved annual budget is affirmed.

CONCLUSIONS OF LAW

1) Policy allows for the approval of services exceeding an I/DD Waiver participant's approved annual budget if those services are necessary to reduce the participant's risk of institutionalization.

2) The evidence failed to demonstrate that the Appellant required additional Physical Therapy and Transportation Miles services in excess of her individualized budget to avoid a risk of institutionalization.

3) The Respondent correctly denied the Appellant's request for accommodation to receive services in excess of the Appellant's I/DD Waiver Program budget.

DECISION

It is the decision of the State Hearing Officer to **uphold** the Respondent's denial of the additional 522 units of Physical Therapy and 5,522 units of Transportation Miles under the I/DD Waiver Program.

ENTERED this 3rd day of February 2021.

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Kristi Logan
Certified State Hearing Officer