State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
4190 Washington Street, West
Charleston, WV 25313

Earl Ray Tomblin
Governor

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

August 4, 2011

----- RE: -----Aged/Disabled Waiver Hearing

Dear -----:

Attached is a copy of the Findings of Fact and Conclusions of Law on your hearing held August 2, 2011. Your hearing request was based on the Department of Health and Human Resources' reduction of your homemaker service hours in the Aged/Disabled Waiver Program due to a level of care determination.

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 Aged/Disabled Waiver Program is based on current policy and regulations. Some of these regulations state that for the Aged/Disabled Waiver Program individuals are evaluated by utilizing the Pre-Admission Screening (PAS) tool to assess their functioning abilities in the home. Points are assigned by the nurse based on the information derived from the PAS assessment interview, and the level of care is divided into four categories of assistance. The individual's level of care is determined based on the points assessed during the completion of the PAS. (Aged and Disabled Waiver Manual Section 501)

The information provided during your hearing shows that you continue to meet the medical requirements for Level of Care (C) in the Aged/Disabled Waiver Program.

It is the decision of the State Hearing Officer to **reverse** the proposal of the Department to reduce your level of care under the Aged/Disabled Waiver Program.

Sincerely,

Cheryl Henson
State Hearing Officer
Member, State Board of Review

cc: Erika H. Young, Chairman, Board of Review
BoSS
WVMI / [redacted]

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

IN RE: -----,

Claimant,

v. **ACTION NO.: 11-BOR-1157**

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 Common Chapters Manual, Chapter 700 of the West Virginia Department of Health and Human Resources. This fair hearing was convened on August 2, 2011.

II. PROGRAM PURPOSE:

The ADW Program is defined as a long-term care alternative that provides services that enable an individual to remain at or return home rather than receiving nursing facility (NF) care. Specifically, ADW services include Homemaker, Case Management, Consumer-Directed Case Management, Medical Adult Day Care, Transportation, and RN Assessment and Review.

III. PARTICIPANTS:

-----, Claimant's representative
-----, Claimant
-----, Claimant's witness

Mary McQuain, Esquire, Department's representative
Kay Ikerd, Department's witness
Courtenay Smith, Department's witness

It should be noted that the Department participated in the hearing by conference call.

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

IV. QUESTION TO BE DECIDED:

The question to be decided is whether the Agency was correct in its proposal to reduce the Claimant's Level of Care benefits under the Aged/Disabled Home and Community-Based Waiver Program.

V. APPLICABLE POLICY:

Aged/Disabled Home and Community-Based Services Manual Sections 501

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 Pertinent provisions of Aged/Disabled Waiver Policy Manual
D-2 Request for Hearing dated March 28, 2011
D-3 Eligibility Determination form of April 27, 2010
D-4 Notice of Decision dated March 22, 2011 with attached Eligibility Determination dated March 10, 2011
D-5 Pre-Admission Screening for Aged/Disabled Waiver Services dated March 10, 2011
D-6 Medical Necessity Evaluation dated November 19, 2010
D-7 Letter to Dr. [redacted] dated June 8, 2011
D-8 Letter from ----- to Mary McQuain dated June 6, 2011, with permission to ask Dr. [redacted] for clarification of diagnoses
D-9 Informed Consent and Release of Medical Information dated March 10, 2011

Claimant's Exhibits:

C-1 Diagnosis of Aphasia on physician's prescription pad dated July 29, 2011 for Claimant and signed by a physician at [redacted] Health Care

VII. FINDINGS OF FACT:

1) The Claimant was undergoing a required annual re-evaluation for the Title XIX Aged/Disabled Waiver Program during the month of March 2011.

2) A West Virginia Medical Institute (WVMI) registered nurse, Courtenay Smith, visited the Claimant at her home and completed her Pre-Admission Screening (PAS) medical assessment (D-5) on March 10, 2011. She determined that the Claimant continues to meet the medical requirements for the program; however, she was assessed at a reduced level from the previous determination - Level of Care (B) rather than Level (C). The Claimant received seventeen (17) points during the PAS assessment, which places her in Level (B) care. For Level of Care (C), the Claimant would need at least eighteen (18) points.

3) During the hearing, the WVMI nurse discussed her findings in each relevant category and explained her reasoning for rating the Claimant in each area. The Claimant disagreed with her conclusions, and contends that an additional one (1) point each should be awarded for the medical conditions of aphasia and dysphagia.

4) The nurse documented on the PAS (D-5) that she explained to the Claimant at the start of the assessment that in order to assess points for any of the medical conditions and symptoms provided in the PAS evaluation for consideration, which includes aphasia and dysphagia, she would need to find either evidence of a medical diagnosis or prescribed medication for the condition or symptom.

5) The Claimant contends that sufficient information was provided during the assessment to support an award of one (1) point for aphasia, and claims that the WVMI nurse did not contact the Claimant's physician per policy in order to determine whether the Claimant was diagnosed with this condition. The WVMI nurse recorded the following relevant information during her assessment regarding aphasia:

> Member's speech is limited but she was able to answer most of assessment questions herself. Her husband assisted her as needed. Member has right sided hemiparesis [diagnosis] on referral. Member has difficulty speaking and was noted to have trouble answering assessment questions. No [diagnosis] noted. Member has [diagnosis] of CVA [cerebral vascular accident] noted on referral. Member's speech is impaired and she can only speak a few words at a time at times. She had to use hand gestures or her husband had to interpret what she was trying to say for me.

The WVMI nurse defined aphasia as when an individual has difficulty speaking or expressing one's thoughts with speech. She explained that there are different types of aphasia, such as expressive aphasia, where an individual has difficulty getting the correct words out, often using incorrect words. She added that another form is functional aphasia, where an individual cannot talk, or has difficulty getting words out. She added that she did observe functional aphasia behavior from the Claimant during the assessment. The nurse added that she did not document that she contacted the Claimant's physician in order to clarify the diagnosis, and she does not recall taking this step.

The Claimant presented as evidence (C-1) a diagnosis from Dr. [redacted] at the [redacted] Health Care Clinic in [redacted] This diagnosis was written on prescription pad paper and dated July 29, 2011.

The Claimant contends that the Claimant received points for the diagnosis of aphasia during prior PAS assessments completed in 2009 and 2010, with the 2010 PAS showing a notation that the diagnosis was being allowed because it was listed on the 2009 PAS assessment after having been left off the diagnosis list provided by the physician. The Claimant contends that the listed physician for her is not cooperative in providing medical documentation, and that she obtained a current diagnosis for aphasia from another physician (C-1) as a result.

6) The Claimant contends that sufficient information was provided to support an award of one (1) point for dysphagia, and again claims that the WVMI nurse did not follow policy which provides that WVMI will contact the physician to clarify the diagnosis when necessary. The WVMI nurse recorded the following pertinent information on the PAS:

> Member has difficulty swallowing meats and bulky foods. No [diagnosis] noted.

The WVMI nurse stated that the Claimant's difficulty swallowing meats and bulky foods is possibly related to her injuries sustained from a gunshot wound several years ago. She stated the Claimant's diagnosis of hemiparesis refers to weakness or paralysis on one side of the body, and added that in the Claimant's case the right side of her body was affected.

7) Aged/Disabled Home and Community-Based Services Manual Section 501.3 – MEMBER ELIGIBILITY AND ENROLLMENT PROCESS:

> Applicants for the ADW Program must meet the following criteria to be eligible for the program:
>
> C. Be approved as medically eligible for NF Level of Care.

8) Aged/Disabled Home and Community-Based Services Manual Section 501.3.1.1 states in pertinent part:

> Purpose: The purpose of the medical eligibility review is to ensure the following:
>
> A. New applicants and existing clients are medically eligible based on current and accurate evaluations.
>
> B. Each applicant/client determined to be medically eligible for ADW services receives an appropriate LOC that reflects current/actual medical condition and short and long-term services needs.

C. The medical eligibility determination process is fair, equitable and consistently applied throughout the state.

9) Aged/Disabled Home and Community-Based Services Waiver Policy Manual 501.3.2.1 (D-1) LEVELS OF CARE CRITERIA states in pertinent part:

There are four levels of care for homemaker services. Points will be determined as follows, based on the following sections of the PAS:

#23 Medical Conditions /Symptoms – 1 point for each (can have toal of 12 points

#24 Decubitus – 1 point

#25 1 point for b., c., or d

#26 Functional abilities
Level 1 – 0 points
Level 2 – 1 point for each item a. through i.
Level 3 – 2 points for each item a. through m.; i. (walking) must be equal to or greater than Level 3 before points given for j. Wheeling
#27 Professional and Technical Care Needs – 1 point for continuous oxygen
#28 Medication Administration – 1 point for b. or c.
#34 Dementia – 1 point if Alzheimer's or other dementia
#35 Prognosis – 1 point if Terminal
Total number of points possible is 44

10) Aged/Disabled Home and Community Based Services Waiver Policy Manual 501.3.2.2 LEVELS OF CARE SERVICE LIMITS states:

Level	Points Required	Hours Per Day	Hours Per Month
A	5-9	2	62
B	10-17	3	93
C	18-25	4	124
D	26-44	5	155

The total number of hours may be used flexibly within the month, but must be justified and documented on the POC. Example: If the POC shows 4 hours/day, Monday-Thursday and 5 hours on Friday, the additional hour on Friday must be justified on the POC.

11) Aged/Disabled Home and Community Based Services Waiver Policy Manual 501.3.4 states in pertinent part:

C. …the QIO RN, through observation and/or interview process, completes the PAS. The RN will record observations and findings

regarding the member's level of function in the home. RNs do not render medical diagnoses.

D. In those cases where there is a medical diagnosis question, the QIO RN will attempt to clarify the information with the referring physician. In the event that the RN cannot obtain the information, he/she will document such, noting that supporting documentation from the referring physician was not received.

VIII. CONCLUSIONS OF LAW:

1) Policy dictates that there are four levels of care for homemaker services. Points are determined based on the individual's medical condition and functional abilities at the time the PAS is completed. Points are assigned accordingly.

2) The Claimant was assessed at Level of Care (B) during her March 10, 2011 assessment, having received seventeen (17) points. To be assessed at Level of Care (C) the Claimant must be assigned at least eighteen (18) points during the assessment.

3) Policy provides that during the assessment process, the Department is to complete the PAS by means of both observation and/or an interview process in order to determine the individual's functional ability in the home. Although policy is found that indicates the nurse is not to render medical diagnoses, policy requires the nurse to contact the individual's referring physician in an attempt to clarify the diagnosis when there is a question.

4) The totality of the testimony and evidence provided during this hearing supports that the Claimant also has the medical diagnosis of aphasia. The WVMI nurse clearly observed the Claimant having difficulty with speech during the assessment consistent with one diagnosed with aphasia, and the Claimant reported that she has been diagnosed with aphasia. The nurse did not contact the physician in order to clarify the diagnosis. The Claimant presented evidence of the diagnosis during the hearing. As such, an additional one (1) point is awarded for aphasia.

5) The evidence is not sufficient to support that the Claimant should have been assessed the diagnosis of dysphagia during the PAS assessment. Although she clearly reported having difficulty swallowing and the nurse did not contact the physician for clarification of this diagnosis, no evidence was provided to support a physician's diagnosis of dysphagia.

6) With the additionally awarded one (1) point for aphasia, the Claimant now has a total of eighteen (18) points, which supports a Level of Care (C). The Department was not correct in its decision to reduce the Claimant's Level of Care from Level (C) to Level (B).

IX. DECISION:

It is the decision of the State Hearing Officer to **reverse** the Agency's proposal to reduce the Claimant's Level of Care from Level (C) to Level (B).

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 4th Day of August, 2011.

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Cheryl Henson
State Hearing Officer