August 8, 2024

[redacted]

RE: [redacted] v. WVDOHS
ACTION NO.: 24-BOR-1829

Dear [redacted]:

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 Human Services. 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,

Todd Thornton
State Hearing Officer
Member, State Board of Review

Encl: Recourse to Hearing Decision
Form IG-BR-29

cc: Connie Sankoff, Department Representative
Susan Silverman, Department Representative

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 24-BOR-1829**

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES BUREAU FOR MEDICAL SERVICES,

Respondent.

DECISION OF STATE HEARING OFFICER

INTRODUCTION

This is the decision of the State Hearing Officer resulting from a fair hearing for [redacted]. This hearing was held in accordance with the provisions found in Chapter 700 of the Office of Inspector General Common Chapters Manual. This fair hearing was convened on July 25, 2024, upon a timely appeal filed on March 27, 2024.

The matter before the Hearing Officer arises from the March 8, 2024 decision by the Respondent to terminate Aged/Disabled Waiver (ADW) Services to the Appellant based on unmet medical eligibility.

At the hearing, the Respondent appeared by Connie Sankoff. Appearing as a witness for the Respondent was Erika Blake. The Appellant was self-represented. The Appellant is deaf and appearing as the interpreter for the Appellant and a witness was [redacted]. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

D-1	BMS Provider Manual, Chapter 501 (excerpt)
D-2	Hearing Request form
D-3	(Not admitted)
D-4	Aged and Disabled Waiver Program Medical Necessity Evaluation Request form

D-5	Pre-Admission Screening (PAS) form, dated February 20, 2024
D-6	PAS Summary form, dated February 20, 2024
D-7	PAS form, dated March 1, 2023
D-8	PAS Summary form, dated March 1, 2023
D-9	Notice of decision (Potential Termination), dated February 20, 2024
D-10	Notice of decision (Final Termination), dated March 8, 2024
D-11	(Not admitted)

Appellant's Exhibits:

None

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 was a recipient of Aged/Disabled Waiver (ADW) Services.

2) The Appellant completed a review of his medical eligibility for ADW Services in 2023.

3) The assessing nurse for the Respondent noted her findings from this review in a Pre-Admission Screening (PAS) document, dated March 1, 2023. (Exhibit D-7)

4) The PAS summary document (Exhibit D-8) from the March 2023 assessment of the Appellant showed that he obtained deficits in five (5) assessment elements: *vacating* (the home in the event of an emergency), *eating*, *bathing*, *dressing*, and *grooming.*

5) The Appellant completed the most recent review of his medical eligibility for ADW Services in 2024.

6) During both the 2023 and 2024 assessments, the Appellant was noted to be deaf. (Exhibits D-5 and D-7)

7) During both the 2023 and 2024 assessments, the Appellant was noted to have hand contractures. (Exhibits D-5 and D-7)

8) During both the 2023 and 2024 assessments, the Medical Power of Attorney (MPOA) for the Appellant was [redacted] (Exhibits D-4, D-5, and D-7)

9) The 2023 PAS (Exhibit D-7) notes, "The following individuals were present Applicant [redacted] family friend [redacted] MPOA [redacted] and [Respondent assessing nurse]."

10) [redacted] was present for the 2023 assessment. (Exhibit D-7)

11) The 2024 PAS (Exhibit D-5) notes, "The following individuals were present [redacted] step mother, [redacted] and [Respondent assessing nurse]."

12) The 2024 PAS additionally identified [redacted] as the Appellant's case manager with [redacted] (Exhibit D-5)

13) [redacted] was not present for the 2024 assessment.

14) The 2024 PAS (Exhibit D-5), under notes for *Communication*, reads, "Speech was not clear, but was understandable and appropriate, member completed the PAS with assistance from the MPOA."

15) The Appellant's MPOA was not present for the 2024 assessment. (Exhibit D-5)

16) During both the 2023 and 2024 assessments, the Appellant was found "…unable to fully extend arms above head." (Exhibits D-5 and D-7)

17) The Appellant was found to require physical assistance with *bathing* and *grooming* in 2023 but was found independent in these areas in 2024. (Exhibits D-5 and D-7)

18) During both the 2023 and 2024 assessments, the Appellant was found "…unable to bend at the waist while seated and touch feet with hands." (Exhibits D-5 and D-7)

19) The Appellant was found to require physical assistance with *dressing* and *grooming* in 2023 but was found independent in these areas in 2024. (Exhibits D-5 and D-7)

APPLICABLE POLICY

BMS Provider Manual, Chapter 501, § 501.12, provides:

> The UMC is the entity that is responsible for conducting, and reviewing existing nursing facilities, for TMH applicants/participants, medical necessity assessments to confirm an applicant's medical eligibility for waiver services. The purpose of the medical eligibility review is to ensure the following:

• New applicants and existing members are medically eligible based on current and accurate evaluations.

• Each applicant/member determined to be medically eligible for ADW services receives an appropriate Service Level that reflects current/actual medical condition and short and long-term service needs.

• The medical eligibility determination process is fair, equitable, and consistently applied throughout the State.

BMS Provider Manual, Chapter 501, § 501.12.1 provides:

An individual must have five deficits as described on the PAS to qualify medically for the ADW program. These deficits are derived from a combination of the following assessment elements on the PAS.

Section	Description of Points	
#24	Decubitus; Stage 3 or 4	
#25	In the event of an emergency, the individual is c) mentally unable or d) physically unable to vacate a building. a) Independently and b) With Supervision are not considered deficits	
#26	Functional abilities of individual in the home	
a.	Eating	Level 2 or higher (physical assistance to get nourishment, not
b.	Bathing	Level 2 or higher (physical assistance or more)
c.	Dressing	Level 2 or higher (physical assistance or more)
d.	Grooming	Level 2 or higher (physical assistance or more)
e. f.	Continence, Bowel Continence, Bladder	Level 3 or higher; must be incontinent
g.	Orientation	Level 3 or higher (totally disoriented, comatose).
h.	Transfer	Level 3 or higher (one-person or two-person assistance in the home)
i.	Walking	Level 3 or higher (one-person or two-person assistance in the home)
j.	Wheeling	Level 3 or higher (must be Level 3 or 4 on walking in the home to use Level 3 or 4 for wheeling in the home. Do not count outside the home)
#27	Individual has skilled needs in one or more of these areas: (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations	
#28	Individual is not capable of administering his/her own medications	

BMS Provider Manual, Chapter 501, § 501.4 provides:

When reference is made to "applicant/member" in this manual, it also includes any person who may, under State law, act on the person's behalf when the person is

unable to act for himself or herself. That person is referred to as the person's legal representative. There are various types of legal representatives, including but not limited to: guardians, conservators, power of attorney representatives, health care surrogates and representative payees. Each type of legal representative has a different scope of decision-making authority. For example, a court-appointed conservator might have the power to make financial decisions, but not health care decisions. The ADW case manager must verify that a representative has the necessary authority and obtain copies of supporting documentation, e.g., court orders or power of attorney documents, for the member's file.

Legal representatives must always be consulted for decisions within their scope of authority. However, contact with or input from the legal representative should not replace contact and communication with the member. If the member can understand the situation and express a preference, the member should be kept informed, and their wishes respected to the degree practicable.

A court appointed legal guardian authorized by the court to make healthcare decisions for the applicant/member is required to:

- Attend and sign the initial medical eligibility assessment,
- Attend and sign subsequent annual medical eligibility assessments,
- Sign the initial and annual Medical Necessity Evaluation Request (MNER), and
- Attend the meetings to develop the Service Plan and sign the initial and annual Person-Centered Assessment.

Note: Adult Protective Services (APS) as the appointed guardian is responsible for attending the meetings listed above. As the guardian they must approve and sign off on all decisions, except financial, relating to the protected person. Attending and participating in the scheduled meetings is a fiduciary obligation that ensures all services are in the client's best interest.

BMS Provider Manual, Chapter 501, Glossary, defines "Legal Representative" as:

One who stands in the place of and represents the interest of another, i.e., Power of Attorney, Medical Power of Attorney, Medical Surrogate.

BMS Provider Manual, Chapter 501, §501.12.2.5, provides:

Annual re-evaluations for medical eligibility for each member must be conducted.

- The case management agency will be alerted by the UMC portal that the MNER needs to be updated.
- The case manager updates the MNER then submits.

• Once submitted the UMC will receive an alert that the MNER was updated.

• The UMC contacts the ADW member and schedules the PAS no later than 45 days prior to the Anchor date but may schedule the PAS as early as 90 days prior to the Anchor Date. A letter is sent to the member, legal representative/designated contact and notification is sent to the case management agency noting the date and time of the assessment.

• If the UMC is unable to contact the member, legal representative/designated contact within three attempts, a Potential Closure letter will be sent to the member, legal representative/designation contact. Notification is sent to the case management agency, Personal Options vendor, and the TMH office, as applicable.

• If no contact is made with the UMC within 10 business days of the date of the Potential Closure letter, the UMC will send the Final Denial letter to the member, legal representative/designated contact. The OA, case management agency, Personal Options vendor, and the TMH office, as applicable will be notified. The OA will close the case.

DISCUSSION

The Appellant requested a hearing to contest the Respondent's decision to terminate his ADW Services based on unmet medical eligibility. The Respondent must show, by a preponderance of the evidence, that its decision was correct.

ADW policy requires an initial determination of medical eligibility and subsequent medical re-evaluations, and the results of these determinations are recorded in a Pre-Admission Screening (PAS) form. The Appellant had received ADW services in the past and was terminated as the result of a recent redetermination by the Respondent.

The Appellant was awarded five (5) deficits on his 2023 PAS, and only two (2) on his 2024 PAS. The results of a prior PAS do not necessarily have any connection to current assessment conditions, as conditions change and policy requires regular re-evaluations. However, the Appellant has hand contractures, which were noted to not typically improve, and the Appellant is deaf and had a MPOA.

Policy requires legal representatives to be notified of the medical re-evaluation process. It requires legal representatives to "…always be consulted for decisions within their scope of authority," and, while it stresses the importance of "contact and communication with the member," this is conditioned on "if the member can understand and express a preference." The Appellant relies on a person to translate for him as he is deaf.

During 2023, this person was his MPOA, [redacted] During 2024, [redacted] was still noted as the Appellant's MPOA. Policy defines legal representatives as including an MPOA. The MPOA was noted as present for the 2024 PAS assessment in PAS notes, but the same PAS notes did not list [redacted] as present. Both the hand contractures and the noted inabilities – each corresponding to the ability to perform bathing, dressing, and grooming activities – did not change

from the 2023 to the 2024 assessments, but the corresponding activities were rated as improved to 'independent' or 'self/prompting' from the prior year's levels of requiring 'physical assistance.'

These discrepancies and the unmet requirement to consult the MPOA at the time, who clearly should have been involved in the assessment, make the current PAS unreliable. The Respondent has based its decision on this assessment, and it cannot be affirmed. Because policy requires medical re-evaluations, the Appellant cannot avoid this step. The decision of the Respondent to terminate the Appellant's ADW Services is therefore reversed, and the matter remanded to the Respondent to re-initiate the medical re-evaluation process and ensure that the evaluation is completed with the appropriate legal representative(s) and translator present to make all communication during the assessment reliable and clear.

CONCLUSIONS OF LAW

1) The Appellant was a recipient of ADW benefits.

2) The Appellant had a legal representative, in the form of an MPOA.

3) The Appellant's legal representative was not present for the 2024 assessment of his medical eligibility.

4) Policy requires the input of a member's legal representative when "within their scope of authority."

5) The medical assessment of the Appellant is within the scope of the authority of the Appellant's MPOA.

6) The 2024 medical assessment of the Appellant showed inconsistencies between stated abilities and the resulting deficit ratings.

7) The 2024 medical assessment of the Appellant inconsistently noted that the MPOA was present, but in further notes was listed as not present.

8) The 2024 medical assessment of the Appellant is unreliable.

9) The Respondent must not terminate the ADW services of the Appellant based on this assessment.

10) The matter is remanded to the Respondent to determine the Appellant's medical eligibility anew, and to ensure that all persons required by policy and necessary to ensure clear communication during the assessment are present.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the decision of the Respondent to terminate the Appellant's ADW Services based on unmet medical eligibility. The matter is **REMANDED** to the Respondent to redetermine the Appellant's medical eligibility with all necessary persons present.

ENTERED this _____ day of August 2024.

_____

Todd Thornton
State Hearing Officer