IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA HUNTINGTON DIVISION

BELINDA CYRUS on behalf of Mildred McSweeney, GEORGE JEFFERSON, and PAUL ROBERT BOGERT, on behalf of a class of individuals similarly situated,

Plaintiffs,

v.

Civil Action No. 04-0892

MARTHA YEAGER WALKER, in her capacity as Secretary, West Virginia Department of Health and Human Services,

Defendant.

AGREED ORDER

Now come the Plaintiffs and the Defendant, by counsel, and represent to the Court that they have compromised and resolved the claims asserted in the above-styled matter.

1. The parties have agreed to the following procedures and requirements applicable only to the West Virginia Medicaid Home and Community Based Aged/Disabled Waiver Program (hereinafter "ADWP").

2. **New Applications.**

a. An applicant to the ADWP shall initially apply to the program by having her/his treating physician submit a referral[1] using the attached

[1]Currently the Defendant makes referrals to West Virginia Medical Institute ("WVMI"). However the procedure provided in the Agreed Order shall apply to the Defendant or any subsequent entity designated to perform eligibility determinations for the ADWP program in the future.

Evaluation Request Form. (See Ex. A.) The form requests the physician submit the individual's identifying information, including, among other things: (1) medical diagnoses and any comments; (2) terminal prognoses; (3) identification of guardian, committee, power of attorney, or other personal representative; (4) identification of whether the individual suffers from Alzheimer's, multi-infarct, senile dementia, or related condition; and (5) other pertinent medical documentation.

b. A nurse then attempts to contact the individual and or contact person to schedule a home visit allowing at least two weeks notice. If contact is made, a notice shall be sent to the individual and or contact person so noting the contact and home visit date. If the individual has identified a guardian, no home visit shall be scheduled without presence of the guardian, contact person or legal representative; and/or if the Evaluation Form indicates that the individual suffers from Alzheimer's, multi-infarct, senile dementia, or related condition dementia, no home visit shall be scheduled without another individual designated by the applicant present to assist the individual during the interview.

c. If a home visit is scheduled, the visit is made and the nurse, through an observation and interview process, completes the Pre-Admission Screening Form ("PAS-2000"). The nurse shall record observations and findings regarding the individual's level of function.

d. Nurses shall not render medical diagnoses. In those cases where there is a medical diagnosis question, the decision shall be based on medical evidence presented by appropriate medical professionals.

i. **Approval.** If the individual is determined medically eligible, a Notice of Approved Medical Eligibility, is sent to the individual and the referring physician.

ii. When an ADWP slot becomes available, a second Notice of Approved Medical Eligibility, including the maximum number of in-home care hours approved per month, is sent to the individual, the referring physician, and the identified representative advising of the need to choose a case management agency or choose the self-directed case management option. The Case Management Selection Form shall be sent only to the individual and identified representative. A listing of case management agencies in the individual's area, along with a copy of the individual's PAS-2000 are included with the Notice. Should the individual fail to decide, Bureau for Senior Services ("BOSS") will be notified of that fact, and BOSS will assign the individual a case management agency serving the individual's area that it selects on a rotating basis. Upon notification of the selected case management agency or self-directed case management option by BOSS, the

individual and the case management agency are sent a copy of the individual's PAS-2000.

iii. **Denial.** Should it be determined that there is no medical eligibility, the individual, the referring physician, and any identified representative shall be notified of a Potential Denial of the referral and given two weeks to submit supplemental information. The Notice of Potential Denial shall advise the individual of the reason for the potential denial, *i.e.*, areas in which deficiencies are found and notice that the medical eligibility standard has not been met. (See Ex. B.) A copy of the individual's PAS-2000 and ADWP Policy shall be enclosed. If supplemental information is received, it is returned to the nurse.

iv. Should the review of the supplemental information determine there is still no medical eligibility, the individual, the referring physician, and any identified representative shall be notified of a Final Denial. The Final Denial shall provide the reason for the adverse decision, applicable policy manual section, and advise the individual of their right to contest the decision. (See Ex. C.) A copy of the individual's PAS-2000, the relevant ADWP Policy, the individual's supplemental documentation, if provided, a Request for Hearing Form (see Ex. D), and notice of the

availability of free legal services will be included with the Final Denial.

3. **Re-evaluations.**

a. Annual re-evaluations of medical necessity for each ADWP participant shall be conducted. The re-evaluation process shall be triggered by the individual and/or their case management agency submitting: (1) an updated–Evaluation Form and, (2) any updated and pertinent medical documentation provided by the recipient's treating physician. (See Ex. A.)

b. After receiving the completed updated Evaluation Request Form and any other medical documentation relevant to the medical necessity reevaluation from the recipient's treating physician, or the individual and/or their case management agency, a nurse shall attempt contact with the individual or contact person to schedule a home visit allowing at least two weeks notice. If the individual has identified a guardian or legal representative, no home visit shall be scheduled without presence of the guardian, contact person, or legal representative; and/or if the Evaluation Form indicates that the individual suffers from Alzheimer's, multi-infarct, senile dementia, or related condition, no home visit shall be scheduled without the guardian, contact person, or legal representative present to assist the individual in the interview. If contact is made, a notice is sent to the individual, their case management agency, and contact person so noting the contact and home visit date.

c. If a home visit is scheduled, the visit is made and the nurse through an observation and interview process completes the PAS-2000. The nurse records observations and findings regarding the individual's level of function.

d. Nurses shall not render medical diagnoses. In those cases where there is a medical diagnosis question, the decision shall be based on medical evidence presented by appropriate medical professionals.

i. **Approval.** If the recipient is determined to be medically eligible, a Notice of Approved Continued Medical Eligibility, which includes the Level of Care and Number of Hours of Service determination, notice of appeal rights and availability of free legal services to eligible individuals, are sent to the individual, their case management agency, and any identified representative.

ii. If the individual disagrees with the determination of Level of Care and/or Number of Hours determination, they may file an appeal with BMS in accordance with the regulations governing such appeals.

iii. **Denial.** Should the recipient be determined not to be medically eligible, the individual and or contact person, the referring physician, and the case management agency shall be notified of a Potential Denial of the referral and given two weeks to submit supplemental information. The Notice of

Potential Denial shall advise the individual of the reason for the potential denial, *i.e.*, areas in which deficiencies are found and notice that the medical eligibility standard has not been met. (See Ex. B.) A copy of the individual's PAS-2000 and relevant ADWP Policy shall be enclosed. If supplemental information is received, it is returned to the nurse.

iv. Should the review of the supplemental information determine there is still no medical eligibility, the individual and or contact person, the referring physician, and the case management agency shall be notified of a Final Denial. The Final Denial shall provide the reason for the adverse decision and advise the individual of their right to contest the decision. (See Ex. C.) A copy of the individual's PAS-2000, relevant ADWP Policy, the individual's supplemental documentation, if provided, a Request for Hearing Form (see Ex. D), and notice of the availability of free legal services shall be included with the Final Denial.

v. If a recipient elects to appeal any adverse decision, benefits shall continue at the current level only if the appeal is mailed within thirteen (13) days of the notice date, and only until a final decision is rendered by the administrative Hearing Officer.

4. The Defendant is responsible for ensuring that WVMI or any subsequent contractor comply with the provisions of this Order and any constitutional, statutory and/or regulatory requirements applicable to the ADWP program.

5. The Defendant agrees to pay Plaintiffs an agreed upon amount of their reasonable attorney's fees and the costs of this action. Notwithstanding the full release and satisfaction of the claim as set forth below, the parties agree that if they are unable to resolve the issue regarding the amount of reasonable attorney's fees to which the plaintiffs may be entitled, the parties stipulate that this issue may be litigated separate and apart from the release of the other claims under the Amended Complaint.

IT IS SO ORDERED. The parties agree that this Order represents a resolution of all claims raised by the Amended Complaint. The Plaintiffs' claims thus are hereby dismissed with prejudice, except for the resolution regarding the plaintiff's claim for attorneys fees. The Clerk is directed to forward a copy of this Order to counsel of record.

ENTERED March 23, 2005

HONORABLE ROBERT "CHUCK" CHAMBERS
UNITED STATES DISTRICT JUDGE

Agreed to by:

Bren J. Pomponio (WV State Bar No. 7774)
Daniel Hedges (WV State Bar No. 1660)
Mountain State Justice
922 Quarrier Street, Suite 525
Charleston, WV 25301
304/344-3144

Jane Perkins
National Health Law Program
211 N. Columbia Street
Chapel Hill, NC 27514
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304 558-6063

COUNSEL FOR DEFENDANT

WEST VIRGINIA MEDICAL INSTITUTE, INC.
Evaluation Request
CONFIDENTIAL

WVMI LOCAL FAX # 304-346-8948**WVMI TOLL FREE FAX # 1-888-296-5144

_____initial _____ re-evaluation

ENTIRE FORM MUST BE COMPLETED IN ORDER TO PROCESS

APPLICANT INFORMATION:

NAME: _____ BIRTHDATE: ___/___/___
SS# : _____/_____/_____TELEPHONE#_____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
COUNTY: _____ MEDICAID # (IF AVAILABLE): _____

CHECK ONE IF APPLICABLE:

GUARDIAN _____
POWER OF ATTORNEY _____
COMMITTEE _____

CONTACT PERSON: _____ PHONE NUMBER: _____
(If other than applicant)
CONTACT'S ADDRESS _____

RELATIONSHIP TO APPLICANT _____

SIGNATURE OF APPLICANT OR REPRESENTATIVE:
_____ DATE: _____

REFERRING PHYSICIAN'S INFORMATION:

NAME: _____
OFFICE ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____ FAX: _____

APPLICANT'S DIAGNOSES (WITH COMMENTS):
_____
_____
_____

DOES THE INDIVIDUAL HAVE ALZHEIMER'S, MULTI-INFARCT, SENILE DEMENTIA, OR RELATED CONDITION?_____

ANY OTHER PERTINENT MEDICAL CONDITIONS:
_____
_____

PROGNOSIS: IS THE PATIENT TERMINAL? (circle one) Yes No

PHYSICIAN'S SIGNATURE (Original Required):

_____ **DATE:** _____

WVMI
West Virginia Medical Institute
"Dedicated to improving the health of the people we serve."

3001 Chesterfield Place
Charleston, WV 25304
Phone 304-346-9864 ext 3279
Toll free 1-800-982-6334 ext 3279
Fax 304-346-8948

Date

Client Name
Address

POTENTIAL DENIAL

Dear, Sir or Madam:

At your request, a WVMI nurse recently visited you and completed an assessment to determine medical necessity for Medicaid's Aged & Disabled Waiver Program.

Medical necessity is based on information you provided to the nurse, which was documented on a form called the Pre-Admission Screening Form or PAS. A copy of your PAS is enclosed.

To be eligible for benefits you must be deficient in at least 5 of 13 critical areas as mandated in the Medicaid Program Regulations, Aged/Disabled Home and Community Based Services Waiver, Policy and Procedures Manual, Chapter 570.1. See attached criteria.

Based on your PAS you have deficiencies in only __ areas. The areas in which deficiencies were found are checked below.

- ☐ Decubitus
- ☐ Vacate a Building
- ☐ Eating
- ☐ Bathing
- ☐ Grooming
- ☐ Dressing
- ☐ Continence
- ☐ Orientation
- ☐ Transfer
- ☐ Walking
- ☐ Wheeling
- ☐ Skilled Needs
- ☐ Administering Medications

Since your PAS did not indicate the required deficits, your request for benefits cannot be approved.

If you believe you have additional information regarding your medical condition that wasn't considered, please submit those records to WVMI *within the next 2 weeks*.

If no additional information is received **within 2 weeks from the date of this notice**, you will receive a denial notice. The notice will include information on how to appeal if you disagree with the determination, and copies of any supplemental documentation received on your behalf.

Sincerely,

Mark K Stephens M.D

Mark K. Stephens, MD
WVMI – WV Medicaid Medical Director

Enclosures
PAS Screening Form
Policy Manual 570.1

Revised 3/22/05

WVMI
West Virginia Medical Institute
"Dedicated to improving the health of the people we serve."

3001 Chesterfield Place
Charleston, WV 25304
Phone 304-346-9864 ext 3279
Toll free 1-800-642-8686 ext 3279
Fax 304-346-8948

Date

Client Name
Address

NOTICE: YOUR REQUEST FOR BENEFITS UNDER THE HOME AND COMMUNITY BASED AGED/DISABLED WAIVER PROGRAM HAS BEEN TERMINATED/DENIED.

An evaluation of your current medical condition indicates that you are not entitled to services under the A/D Waiver Program. A decision has been made to terminate/deny your homemaker and case management services. You have the right to dispute this decision and ask for a hearing.

REASON FOR DECISION: Eligibility for the Aged/Disabled Waiver Program requires deficits in at least 5 of the health areas below. Your PAS (Pre-Admission Screening Form), indicated deficiencies in ___ areas.

- ☐ Decubitus
- ☐ Vacate a Building
- ☐ Eating
- ☐ Bathing
- ☐ Grooming
- ☐ Dressing
- ☐ Continence
- ☐ Orientation
- ☐ Transfer
- ☐ Walking
- ☐ Wheeling
- ☐ Skilled Needs
- ☐ Administering Medications

(See your PAS Screening Form enclosed)

Because you have less than 5 deficits at the level required, your services are being terminated/denied.

POLICY APPLIED: Medicaid Manual (Age/Disabled Home and Community Based Services Waiver), Chapter 570.1. *See* policy criteria enclosed.

REQUEST FOR A HEARING: If you do not agree with this decision, and wish to appeal to a State Hearing Officer, you must request a Hearing within ***90 days*** of the date of this letter. A form to request a Hearing is enclosed. If you need transportation to the hearing or if you need special accommodations, please check the appropriate box. If you request a hearing within ***13 days*** from the date of a termination notice, your services will continue at the current level until a final decision is made by the hearing examiner.

HEARING AND WITNESSES: At this hearing, you have a right to ask questions of the nurse who completed your PAS (evaluation form). At the hearing, you may bring any other witnesses to testify on your behalf, and to present evidence of your condition at the time the PAS was completed, including independent medical reports if necessary.

LEGAL ASSISTANCE: If you wish to consult with legal counsel on this denial, the following organizations provide free legal services to eligible persons: (1) Legal Aid of WV, 922 Quarrier St., Charleston, WV 25301, 1-800-642-8279; with offices in Beckley, Princeton, Huntington, Wheeling, Parkersburg, Clarksburg, Martinsburg, Logan; or (2) WV Advocates, 1207 Quarrier St., Charleston, WV 25301, 1-800-950-5250.

Sincerely,

Mark K Stephens M.D

Mark K. Stephens, M.D.
WVMI - WV Medicaid Medical Director

Enclosures

PAS Screening Form
Policy Manual 570.1
Request for Hearing Form
Supplemental Medical Documentation
(If applicable)

(Revised 3/22/05)

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES (MEDICAID)
REQUEST FOR HEARING

NAME: _____

ADDRESS: _____

RECIPIENT ID#: _____

TELEPHONE NUMBER WHERE YOU CAN BE REACHED: _____

I, _____, am requesting a fair hearing for the following reason(s):
(Print name)

_____
(Please list service that was denied or terminated. Be as specific as possible. Use other side of form, if necessary for more space.)

You may be contacted by a representative of the Department of Health and Human Resources regarding this request.

You may be requested to participate in a pre-hearing conference (most likely by telephone).

You may choose to participate in your hearing by phone or in person.

Which type of hearing would you prefer (please check one):

_____ Applicant participate by telephone conference
_____ Applicant in person at local office
_____ Applicant to attend hearing at Bureau for Medical Services office in Charleston (with reimbursement for travel mileage, if requested)

This type of hearing can be changed with notice to hearing examiner seven days prior to hearing.

Signature: _____
Date: _____

_____ I need special accommodation for _____
_____ I need help with transportation reimbursement for the hearing.

If hearing is by telephone and you have any documents to present, please mail your documents before the hearing to the hearing examiner whose name is on the hearing notice that you will receive. Please be advised that Department attorneys and nurse witnesses may appear by telephone.

If you will be represented by an attorney or other individual, to the extent you know, list his/her name and address, telephone number:

_____
_____

Return this request to: Bureau for Medical Services
Appeals Sections
Room 251, 350 Capitol Street
Charleston, West Virginia 25301-3706

A Staff member will try to contact you be telephone within approximately five days of receipt of this form. After the telephone contact, you will then be notified in writing of the date and time of the hearing. If we are unsuccessful in contacting you by telephone, you will receive written notice of the hearing date and time within 30 days.

Age/Disabled Waiver Program