

IN THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Ralph K. Anderson, III, Chief Administrative Law Judge

RECEIVED  
MAR 27 2014  
SC Court of Appeals

Case No. 2013-002415

Brook Waddle ..... Appellant,

v.

South Carolina Department of Health and Human Services.....Respondent.

APPELLANT'S RESPONSE TO RESPONDENT'S MOTION TO STRIKE

What makes Respondent's motion so troubling, is that this is a case where the Respondent had a duty of care to the Appellant when DHHS denied payment for an oximeter cable and it has a continuing duty of care to Brook Waddle. *Madison ex rel. Bryant v. Babcock Center, Inc.*, 371 S.C. 123, 638 S.E.2d 650, 656 (S.C. 2006) and 42 C.F.R. 441.302 (States must provide CMS "Assurance that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of the services.) Instead of honoring that duty, Respondent again attempts to prevent the Judicial Branch from reviewing its actions. It is not unusual when dueling former spouses pull out all stops during litigation. Where a business owner is sued by a shopper who slipped and fell in a store, the business owner might be expected to mount an

aggressive defense against the plaintiff to whom she has no ongoing duty. But, Respondent's attempt here ignores the fact that in return for accepting 70% matching funding to administer the Medicaid program, DHHS agreed to comply with federal law. That is the *quid pro quo* - the deal DHHS agreed to accept. But, DHHS has acted as if it has no duty to provide due process to Brook Waddle or to other Medicaid participants. Congress made it unambiguously clear that its intent was not to give States free reign to ignore due process requirements established in the Medicaid Act, in federal regulations and by the United States Supreme Court in *Goldberg v. Kelly*, 397 U.S. 254 (1970). While the Medicaid Act does give States some discretion to limit care and services, within certain mandates contained in the Medicaid Act and the Americans with Disabilities Act, as a condition of accepting federal funds, the State is obligated to administer the Medicaid program "in the recipients' best interests." *Pharmaceutical Research and Manufacturers of America v. Walsh*, 538 U.S. 644, 665 (2003). 42 U.S.C. § 1396a(a)(19) provides that the State Medicaid plan must assure that care and services will be provided "in a manner consistent with . . . the best interests of the recipients".

As Respondent notes in its Motion filed in this Court, the general rule in appellate practice in South Carolina is that the Record in an appeal to this Court shall not include matter which was not presented to the lower court or tribunal. Page 2. First, Appellant did present the matter to which Respondent objects both to the hearing officer (by incorporating the 2007 appeal by reference) and to the lower court. Secondly, the South Carolina Rules of Appellate Practice provide exceptions to this general rule which may be applied by this Court in this case to do justice and to right a wrong that continues to threaten the very life of Brook Waddle.

In any event, Respondent has admitted that the issue of the oximeter cable is contained within the 2007 appeal. Brook draws this Court's attention to Respondent's motion to dismiss her appeal that was filed in the Administrative Law Court, instead of filing a brief in response to Appellant's brief filed in that Court. Exhibit 1. (Respondent's Motion to Dismiss filed in the Administrative Law Court). In that Motion, Respondent informed the Administrative Law Court that Brook's claim in the oximeter proceeding "*is precisely or substantially the same in both proceedings.*" Id. Respondent is bound by that representation to that court and it should not be allowed to change its position now that it wishes to prevent this Court from considering the long history of Brook's saga. The failure of DHHS to provide needed assistive technology devices was specifically included in the grounds of her 2007 appeal. Exhibit 2. Brook has shown that the "proceedings" in this matter include the appeal initiated in 2007, by incorporating by reference information from the appeal filed in 2007 in her Response to the hearing officer's interlocutory order. Exhibit 5.

Pursuant to federal law, the record in this case must consist of "All papers and requests filed in the proceeding." 42 C.F.R. 431.244(b)(2). DHHS was required to provide an evidentiary hearing at which the agency was required to give her an opportunity to "Establish all pertinent facts and circumstances" and to cross-examine the State's witnesses. 42 C.F.R. 431.242. Having blatantly violated 42 C.F.R. 431.244 and Brook's due process rights, now Respondent tries to prevent her from relying upon what information she put into the record before the illegal dismissal of her appeal.

Regardless, this Court may include the information at issue in the Record on Appeal at its

discretion. Rule 210(h), SCACR provides that "*Except as provided by Rule 212 and Rule 208(b)(1)© and (2)*, the appellate court will not consider any fact which does not appear in the Record on Appeal." (Emphasis added.) But those Rules clearly give this Court the authority to consider facts not contained in the Record that was prepared by DHHS and filed in the Administrative Law Court.<sup>1</sup> Brook respectfully requests a finding that she has demonstrated that this Court should justly apply Rule 212 and Rule 208(b)(1)( C) and request that the agency send all materials from the 2007 appeal to the Court for its review and consideration.

Rule 212, SCRAP authorizes this Court to "require copies of all or any part of the transcript of *proceedings or other matter* which was before the lower court or administrative tribunal to be sent up for inspection and consideration." This Court has the authority to "require a report of the trial or hearing, or of any matter relative thereto, to be made by the trial judge or administrative tribunal." Importantly, that rule provides that "These matters shall become part of the Record on Appeal." Brook prays that this Court exercise its authority under this Rule to require the agency to send up copies of the proceedings and all other matters before the lower court and administrative tribunal for this Court's inspection and consideration.

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<sup>1</sup> In determining whether this is an appropriate case where Rules 212(a) should be applied, Brook asks this Court to consider that in most appeals, it is the Appellant who prepares the Record on Appeal, with the Respondent having an opportunity to object or to include additional records. But in Medicaid Appeals, not only is the hearing officer, who serves as judge and jury in these cases, allowed to determine what goes into - and is kept out of - the Record, the agency prepares and files the Record without input from the disabled person. While 42 C.F.R. 431.244(a) requires the hearing officer to base her decision "exclusively" and evidence presented at a fair hearing, in this case...and others...DHHS has simply ignored that federal law and dismissed appeals brought by Medicaid participants arbitrarily without providing an opportunity clearly required by 42 U.S.C. 1396a(a)(3) and federal regulations.

In addition, the information contained in Brook's initial brief should be allowed under Rule 208(b)(1)(C). Certainly the information she has provided on her seven year ordeal to receive medically necessary care at home "throws light upon the questions involved in the appeal." Rule 208(b)(1)(C). Respondent has the same right to respond by providing this Court with its own view of the information Brook has provided, pursuant to Rule 208(b)(2).

Respondent cries that it would be prejudiced by this Court considering the records Appellant has in good faith included in her initial brief. Having trampled on Brook's due process rights for years (as found by the DHHS hearing officer in *B.W. v. DHHS* at Exhibit 3), Respondent now argues that its own due process rights would somehow be improperly affected by this Court if its motion to strike is not granted. But this argument ignores the plain fact that Respondent, by its own illegal acts "denied [itself] the opportunity to object to and address these issues earlier in the process." 42 U.S.C. 1396a(a)(3) gave Brook the right to an evidentiary hearing. Other federal regulations interpreting that Act specifically required DHHS to administer the appeals process in compliance with *Goldberg v. Kelly* and other provisions contained in those regulations. *Supra*. DHHS had control of the proceedings and it chose to ignore the clear and unambiguous requirements of federal law requiring DHHS to hold a hearing at which the State could have presented whatever evidence it chose in opposition to Brook's appeal. 42 C.F.R. 431.244(a). Respondent's decision violated *Goldberg* and 42 C.F.R. 431.223 and the State comes to this Court with unclean hands. It is egregious for these state agencies (DHHS and the Administrative Law Court) within the Executive Branch to fight and violate federal law to prevent a hearing, then claim to be injured by the fact that no evidentiary hearing was held.

Appellant, having argued that the failure to pay for the oximeter cable was included

within the grounds contained in her 2007 appeal cannot now object to DHHS including evidence from the appeal filed in 2007. Thus, Respondent's argument that it is prejudiced by "its inability to do the same" is simply not convincing...and the agency is wrong here legally, ethically and morally.

Finally, Respondent asks this Court if it will not grant its request to strike, to throw Brook back into the abyss by remand to the Administrative Law Court. In her brief, Brook demonstrated that the Administrative Law Court's own 180 day aspirational standard for rendering a decision in Medicaid appeals is double the time allowed by federal law for the State to issue a final administrative decision. Federal law requires a 90 day standard of promptness to be met from the date of the request for the hearing at DHHS. 42 C.F.R. 431.244(f). The Court may take judicial notice of the Administrative Law Court's own Annual Accountability Reports documenting this violation of federal law.

An appellate court's right to take judicial notice of such facts is clearly established. As this Court recently recognized in *McCain v. Brighttharp* (399 S.C. 240, 730 S.E.2d 916, 920 (S.C.App. 2012) in *Bowen v Green*, our Supreme Court took judicial notice that, generally, Baptist churches are governed by their own congregations. *Bowen v. Green*, 275 S.C. 431, 434, 272 S.E.2d 433, 434 (1980). Rule 201 of the South Carolina Rules of Evidence provides that judicial notice may be taken of adjudicative facts where the fact is "not subject to reasonable dispute in that it is either (1) generally known within the territorial jurisdiction of the trial court or (2) capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." In fact, those Rules provide that the court may take judicial notice,

whether requested or not. Id. It is mandatory for the court to take judicial notice “if requested by a party and supplied with the necessary information.” Id. Judicial notice may be taken “at any stage of the proceeding.” Id. The Annual Accountability Reports of the Administrative Law Court are certainly generally known within this Court’s jurisdiction and these reports are capable of accurate and ready determination. Certainly the Respondent is not suggesting that the accuracy of the Administrative Law Court’s Annual Reports is in question? As stated in Appellant’s brief, these reports are available to this Court and the public at

[http://dc.statelibrary.sc.gov/bitstream/handle/10827/9423/ALC\\_Annual\\_Accountability\\_Report\\_2011-2012.pdf?sequence=1](http://dc.statelibrary.sc.gov/bitstream/handle/10827/9423/ALC_Annual_Accountability_Report_2011-2012.pdf?sequence=1)

and

<http://www.scalc.net/pub/FY2012-2013%20ALC%20Accountability%20Report.pdf>

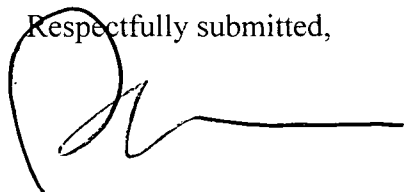
[http://dc.statelibrary.sc.gov/bitstream/handle/10827/12038/ALC\\_Annual\\_Accountability\\_Report\\_2012-2013.pdf?sequence=1](http://dc.statelibrary.sc.gov/bitstream/handle/10827/12038/ALC_Annual_Accountability_Report_2012-2013.pdf?sequence=1).

The reference to the CMS State Medicaid Manual recites language contained in a decision published by the Second Circuit in *Shakhnes v. Berlin*, 689 F.3d 244, fn 11 (2d Cir. 2012). That Manual, like the Administrative Law Court Annual Accountability Reports is generally known within this Court’s jurisdiction, as that Manual is published on CMS’ website and it is capable of accurate and ready determination to be accurate. It is the interpretation of the federal agency chosen by Congress to administer the Medicaid program and must be followed by DHHS, as a condition of participation in the Medicaid program.

Brook’s appeal has been pending now in the Executive Branch for seven years without an opportunity for review by the Judicial Branch of government. The agency and the

Administrative Law Court have each taken multiple bites at the apple, while Brook and her family have suffered and the agency has been allowed to act with conscious disregard for her medical needs and her right to due process. Meanwhile, Brook's condition has deteriorated significantly and her injuries are irreversible, yet the agency has consciously cycled and recycled her case between DHHS and the Administrative Law Court, preventing the Judicial Branch from reviewing their illegal Executive Branch practices. This Court has the authority to order DHHS to send up all documents contained in the 2007 appeal and Brook prays that it exercise this authority and that Respondent's Motion to Strike be denied.

Respectfully submitted,

A handwritten signature in black ink, appearing to be 'Patricia L. Harrison', written over a horizontal line.

Patricia L. Harrison  
611 Holly Street  
Columbia, South Carolina 29205  
Phone: (803) 256-2017  
Fax: (803) 256-2213  
Attorney for Appellant

Columbia, South Carolina  
March 24, 2014

### List of Exhibits

- Exhibit 1. DHHS Motion to Dismiss filed in Administrative Law Court
- Exhibit 2. Appellant's Letter Stating Grounds for Appeal in 2007
- Exhibit 3. DHHS Hearing Officer Decision dated November 19, 2013
- Exhibit 4. DHHS Hearing Officer Decision dated December 23, 2013
- Exhibit 5. Appellant's Response to Order dated March 19, 2013

# Exhibit 1

DHHS Motion to Dismiss filed in Administrative Law Court

STATE OF SOUTH CAROLINA  
ADMINISTRATIVE LAW COURT

|                                         |   |                               |
|-----------------------------------------|---|-------------------------------|
| B.W.,                                   | ) |                               |
|                                         | ) |                               |
| Appellant,                              | ) |                               |
|                                         | ) |                               |
| v.                                      | ) | <b>MOTIONS TO DISMISS OR,</b> |
|                                         | ) | <b>IN THE ALTERNATIVE,</b>    |
| South Carolina Department of Health and | ) | <b>PARTIAL MOTIONS TO</b>     |
| Human Services,                         | ) | <b>DISMISS</b>                |
|                                         | ) |                               |
| Respondent.                             | ) | Docket No. 13-ALJ-08-0267-AP  |
|                                         | ) |                               |
|                                         |   |                               |

TO: Patricia L. Harrison, Esquire, 611 Holly Street, Columbia, South Carolina 29205

Pursuant to Rule 38, SCALCR, and Rules 12(b)(1) and 12(b)(8), SCRCP, Respondent hereby moves to dismiss Appellant's appeal for: (1) Appellant's failure to file a timely Notice of Appeal in accordance with Rule 33, SCALCR; (2) lack of jurisdiction due to Appellant's failure to file her Notice of Appeal timely; (3) Appellant's stated intent to relitigate in this proceeding the same or substantially the same issues raised in a pending proceeding between the same parties. In the alternative, Respondent respectfully moves for dismissal in part of Appellant's claims on the same grounds as stated above.

This appeal arises from the dismissal of Appellant's case by the South Carolina Department of Health and Human Services (SCDHHS) on April 4, 2013. SCDHHS dismissed Appellant's case for abandonment of the appeal and failure to respond to the hearing officer. Appellant filed a Notice of Appeal with the Administrative Law Court (ALC) on June 11, 2013. A Notice of Assignment was issued on June 13, 2013.

**FILED**

SEP 11 2013

ADMINISTRATIVE LAW COURT

**I. Appellant's Appeal Should Be Dismissed Pursuant to Rule 38**

Rule 33, SCALCR, requires that the Notice of Appeal be filed "with the Court and a copy served on each party and the agency whose final decision is the subject of the appeal within thirty (30) days of receipt of the decision from which the appeal is taken." Appellant's Notice of Appeal would have been due for filing on or before May 9, 2013. The Notice of Assignment states the Notice of Appeal was received on June 11, 2013, more than thirty days after receipt of the hearing officer's Order.

Rule 38, SCALCR, states:

Upon motion by any party, or on its own motion, an administrative law judge may dismiss an appeal for failure to comply with any of the rules of procedure for appeals, including the failure to comply with any of the time limits provided by this section.

Therefore, Respondent moves that Appellant's appeal be dismissed for failure to comply with the Court's rules.

**II. Appellant's Appeal Should be Dismissed Pursuant to Rule 12(b)(1), SCRCP, and Rule 33, SCALCR**

A motion to dismiss filed under Rule 12(b)(1), SCRCP, alleging lack of jurisdiction is "purely a question of law for a court." See Woodard v. Westvaco Corp., 215 S.C. 329, 433 S.E.2d 8890 (Ct.App.1993). "Compliance with statutory time periods for filing appeals is a prerequisite for an appellate entity to have jurisdiction to hear an appeal." See Sheppard Construction Co., Inc. v. SCDHEC, 11-ALJ-07-0001-CC (March 28, 2011) (dismissing appeal pursuant to Rule 12(b)(1); SC Coastal Conservation League v. SCDHEC, 380 S.C. 349, 669 S.E.2d 899 (Ct. App. 2008) (reversed on other grounds by SC Coastal Conservation

League v. SCDHEC, 390 S.C. 418, 702 S.E.2d 246 (2010)); Hill v. SCDHEC, 289 S.C. 1, 698 S.E.2d 612 (2010). The South Carolina Supreme Court noted in Botany Bay Marina v. Townsend, 296 S.C. at 334, 372 S.E.2d at 586-87, that:

In Town & Country Civic Organization v. Winston-Salem Zoning Board of Adjustment, . . . the North Carolina Court of Appeals held that the Board's thirty day appeal period rule was binding and the plaintiff's failure to effect a timely appeal extinguished subject matter jurisdiction . . . Likewise, respondent's failure to appeal the Charleston County Board of Adjustment's decision to grant the zoning permits within fifteen days divested the Board of Adjustment of jurisdiction.

Rule 33, SCALCR, requires that the Notice of Appeal be filed with the Court and served on the parties within 30 days of the receipt of the decision from which the appeal is taken. As stated above, Appellant's Notice of Appeal would have been due for filing on or before May 9, 2013, but was not filed with the Administrative Law Court until June 11, 2013, more than thirty days after the receipt of the hearing officer's Order. The Administrative Law Court lacks jurisdiction due to Appellant's failure to file a Notice of Appeal within the designated time period. Therefore, Appellant's appeal should be dismissed pursuant to Rule 12(b)(1), SCRCP.

### **III. Appellant's Appeal Should be Dismissed Pursuant to Rule 12(b)(8), SCRCP**

A motion to dismiss pursuant to Rule 12(b)(8), SCRCP, is proper when: (1) another action is pending; (2) between the same parties; (3) for the same claim. A motion to dismiss under this rule will be granted when a claim is precisely or substantially the same in both proceedings. Capital City Ins. Co. v. BP Staff, Inc., 382 S.C. 92, 674 S.E.2d 524 (Ct. App. 2009). Because each of the components of a Rule 12(b)(8) motion are determined as a

matter of law, a de novo standard of review is applied to determine the grant or denial of this motion. Capital City Ins., 382 S.C. at 100, 674 S.E.2d at 528.

In her Notice of Appeal and brief, Appellant makes frequent and substantial reference to an ongoing proceeding between the parties that began in 2007. Appellant goes so far as to state she is re-alleging claims in this proceeding that she has already made in the other pending action between the parties. Specifically, Appellant states, “The issues raised in this appeal are encompassed in the complaint Appellant filed with DHHS on April 28, 2007 . . . .” (App.Br.p.1; p.15). Appellant’s recitation of some of the issues in the other proceeding shows that they mirror the issues raised in this proceeding. (App.Br.p.4). Furthermore, in support of her same or substantially the same claims in this action, Appellant has included a copy of the transcript and other documentation from the other pending action and references briefs and arguments from 2007 which are not a part of this proceeding. (App.Br.p.15). As references in Appellant’s Notice of Appeal and brief indicate, this appeal is “related to wrongful acts by DHHS occurring after the hearing which was held on October 30 and 31, 2012” and allegations that Respondent has failed to follow the ALC’s order dated July 30, 2012. Appellant clearly refers to the previous and ongoing appeal between Appellant and Respondent and attempts to re-allege those same issues in this appeal.

The current proceeding involves two parties who are participating in another pending action for which Appellant has alleged the same or substantially the same claims. Appellant, per her own words, has re-alleged issues “encompassed in the complaint” filed in 2007, which are still being litigated in another proceeding. Therefore, Appellant’s appeal should be dismissed pursuant to Rule 12(b)(8) because the claims are precisely or substantially the

same in both proceedings. Should this Court find that the issue of the dismissal without hearing regarding the denial of an oximeter cable is not substantially the same as claims in the prior proceeding, Respondent moves the Court grant a partial motion to dismiss in regard to Appellant's other claims that are precisely or substantially the same.

Respectfully submitted,



Shealy B. Reibold, Esquire  
Assistant General Counsel  
Department of HHS  
Post Office Box 8206  
Columbia, South Carolina 29202-8206  
Phone: (803) 898-2792  
Fax: (803) 255-8210  
Attorney for the Respondent

Columbia, South Carolina  
September 11, 2013

# Exhibit 2

Appellant's Letter Stating Grounds for Appeal in 2007

PATRICIA L. HARRISON  
ATTORNEY AT LAW  
611 HOLLY STREET  
COLUMBIA, SOUTH CAROLINA 29205

TELEPHONE (803) 256-2017

FAX (803) 256-2213

28 April 2007

VIA FAX AND MAIL

Dr. Stanley Butkus  
South Carolina Department of Disabilities and Special Needs  
PO Box 4706  
Columbia, South Carolina 29240

Acting Director  
South Carolina Department of Health and Human Service  
PO Box 8206  
Columbia, South Carolina 29202

Mr. Vastine Crouch  
Office of Appeals and Hearings  
South Carolina Department of Health and Human Services  
PO Box 8206  
Columbia, South Carolina 29202

RE: Brook Waddle

Dear Gentlemen:

By this letter, Brook Waddle is appealing the denial of services by the South Carolina Department of Disabilities and Special Needs and the South Carolina Department of Health and Human Services. We have delayed filing this appeal in hopes that these issues would be resolved within 30 days of DDSN's March 30, 2007 denial of nursing services. Unfortunately, these services are still not in place. During the course of this appeal, we are willing to work with both agencies toward returning Brook to her home community. However, we are requesting a final administrative determination within 90 days as required by 42 C.F.R. 431.244. Our grounds for appeal are as follows:

The State has failed to provide Brook Waddle with services under the Head and Spinal Cord Medicaid Waiver in the least restrictive setting, including, but not limited to, nursing services, attendant services, psychological services, assistive technology devices and other services for which appellant is eligible to receive. The State has failed to offer these services to Brook Waddle with reasonable promptness.

The State has failed to notify Brook Waddle of her eligibility for services under the MR/RD Medicaid waiver and to offer these services in the least restrictive setting with reasonable promptness.

The State failed to perform a PASARR assessment and specialized services as required by federal regulations prior to attempting to discharge Brook to an institutional setting.

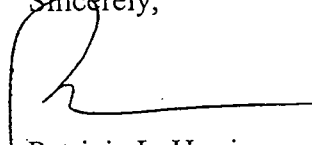
The State has failed to provide EPSDT services as required by the Social Security Act and federal regulations.

The State has improperly limited the hours of services offered to Brook Waddle in violation of the Social Security Act and Title 42 of the Code of Federal Regulations.

The State has acted erroneously in denying requested services in violation of applicable federal case law and regulations.

I have offered to meet with representatives from the South Carolina Department of Health and Human Services and the South Carolina Department of Disabilities and Special Needs and that offer remains open.

Sincerely,



Patricia L. Harrison

cc: Brook Waddle  
Ken Anthony, Esq.  
David Zoellner, Esq.

# Exhibit 3

November 19, 2013 order of DHHS hearing officer in B.W. v. DHHS

rec'd Nov 20, 2013  
Pkt

Nikki Haley GOVERNOR  
Anthony Keck DIRECTOR  
P.O. Box 8206 • Columbia, SC 29202  
[www.scdhhs.gov](http://www.scdhhs.gov)

November 19, 2013

**CERTIFIED MAIL**

Patricia Harrison, Esquire  
611 Holly Street  
Columbia SC 29205

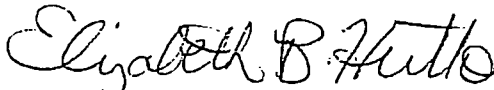
RE: Administrative Decision in the Appeal Matter of Brook Waddle v. SCDHHS  
Appeals' Case # 07-MISC-028  
Medicaid # 6780499394

Dear Ms. Harrison:

Enclosed please find the Administrative Decision in the above-referenced matter.

Any party has the right to petition for further review of this Decision, as provided in the Administrative Procedures Act. S.C. Code Ann. Section 1-23-310, et seq., (1976, as amended). To request an appeal, a Notice of Appeal must be filed with the Administrative Law Court, 1205 Pendleton Street, Brown Building—Suite 224, Columbia, S. C. 29201-3755 within 30 days of the receipt of this Decision. A copy of the Notice of Appeal should be provided to counsel for the opposing party. The Notice of Appeal must be submitted in accordance the Rules of Procedure for the S.C. Administrative Law Court. This matter was previously transcribed to assist me in producing this Decision. I believe the attorneys for both parties have a copy of this transcript. Should either party pursue an appeal, I will certify the transcript and produce it to the Administrative Law Court.

Sincerely,



Elizabeth B. Hutto  
Program Director, Division of Appeals and Third Party Liability  
Interim CFO, SCDHHS

EBH/ss  
Enclosures (2)

Patricia Harrison Esquire

November 19, 2013

Page Two

cc: George Maky, Department Head, Community Waivers, SCDHHS  
Office of General Counsel, SCDHHS  
Richard Hepfer, Esquire, Deputy General Counsel, SCDHHS  
Tana Vanderbilt, Office of General Counsel, SCDDSN  
Linda Veldheer, Director, HASCI Waiver, SCDDSN  
Brook Waddle  
Sandra Waddle

## **71. Filing Fee.**

**A. Cases for which Fee Required.** Each request for a contested case hearing, notice of appeal, or request for injunctive relief before the Court must be accompanied by a filing fee in the amount set forth in Rule 71(C). A case will not be assigned to an administrative law judge and will not be processed until the filing fee has been paid or a waiver has been granted pursuant to Rule 71(B). This fee is not required for contested cases, appeals, or requests for injunctive relief brought by the State of South Carolina or its departments or agencies. For appeals brought pursuant to *Al-Shabazz v. State*, 338 S.C. 354, 527 S.E.2d 742 (2000), the fee will be assessed only for the seventh and subsequent appeals filed by an inmate during a given calendar year.

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**B. Request for Waiver.** A party who is unable to pay the filing fee may request a waiver of the fee by filing a completed Request for Waiver form with the Clerk of the Court at the same time the request for a contested case, notice of appeal, or request for injunctive relief is filed with the Court. Request for Waiver forms shall be issued by the Clerk of the Court. If the filing fee is not waived, the party must pay the filing fee within ten days of the date of receipt of the order denying waiver of the filing fee. If the filing fee for a case is waived on behalf of a party, any motions filed by that party in that case are exempt from the motion fee as provided in Rule 71(D).

**C. Schedule of Filing Fees.** The filing fee will be assessed according to the following schedule:

| Case Type | Fee |
|-----------|-----|
|-----------|-----|

|                                    |      |
|------------------------------------|------|
| Dept. of Health and Human Services | \$50 |
|------------------------------------|------|

**D. Motion Fees.** A fee of \$25 will be imposed for the following motions filed with the Court:

- (1) Motion for Summary Judgment
- (2) Motion to Intervene
- (3) Motion to Dismiss
- (4) Motion for Injunctive Relief (in a pending case).
- (5) Motion to Compel

The fee must be submitted to the Clerk of the Court at the same time the motion is filed, unless a waiver of the filing fee in the case was previously granted to the party filing the motion. A motion will not be deemed filed until the fee is paid. The motion fee is not required for motions filed by the State of South Carolina or its departments or agencies.

### **2009 Revised Notes**

Rule 71 provides for a schedule of filing fees as authorized by law. The filing fee varies according to the type and complexity of the case. The fee is required for all requests for a contested case hearing, notices of appeal, or requests for injunctive relief except for those brought by the State of South Carolina or its departments or agencies. For those appeals brought pursuant to *Al-Shabazz v. State*, 338 S.C. 354, 527 S.E.2d 742 (2000), the fee applies only to the third and subsequent filings by an inmate during a given calendar year. If a party is unable to pay the filing fee, he may request a waiver of the fee by filing the prescribed form with the Clerk of the Court. A case will not be assigned to an administrative law judge until the filing fee has been received or a waiver has been granted. Subsection (D) provides for a twenty-five dollar motion fee for certain motions filed with the Court. A motion will not be deemed filed with the Court until the fee has been paid. However, the motion fee is not required for motions filed by the State of South Carolina or its departments or agencies. In addition, if a party is granted a waiver of the filing fee, any fees for motions filed by that party are likewise waived.

|                                     |   |                              |
|-------------------------------------|---|------------------------------|
| STATE OF SOUTH CAROLINA             | ) | BEFORE THE DIVISION OF       |
|                                     | ) | APPEALS AND HEARINGS         |
| COUNTY OF RICHLAND                  | ) | SOUTH CAROLINA DEPARTMENT OF |
|                                     | ) | HEALTH AND HUMAN SERVICES    |
| B.W.,                               | ) |                              |
|                                     | ) |                              |
| Petitioner,                         | ) | FINAL ADMINISTRATIVE         |
|                                     | ) | ORDER                        |
| -v-                                 | ) |                              |
|                                     | ) |                              |
| South Carolina Department of Health | ) |                              |
| and Human Services,                 | ) | Appeals' Case #: 07-MISC-028 |
|                                     | ) | (Remanded)                   |
| Respondent.                         | ) |                              |
| _____                               | ) |                              |

### **JURISDICTION**

Procedure in this case is governed by the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services to administer various programs and grants (See e.g., S.C. Code Ann. § 44-6-10, et seq.). This appeal has been conducted pursuant to the provisions of the Appeals and Hearings regulations of the South Carolina Department of Health and Human Services (27 S.C. Code Regs. 126-150, et seq.) and the South Carolina Administrative Procedures Act (S.C. Code Ann. § 1-23-310, et seq.).

### **BACKGROUND**

The Petitioner in this matter was injured in an automobile accident in 2005, which rendered her quadriplegic. At the time of the accident, the Petitioner was 17 years old. She has difficulty speaking due to subsequent injuries to her larynx sustained during her initial hospitalization. She breathes through a tracheostomy. The Petitioner became eligible for Medicaid-covered services shortly after the accident. Since her May, 2007 return home, she has been receiving services under the South Carolina Head and Spinal Cord Injury (HASCI) Waiver. Under this Waiver, beneficiaries can be provided a mix of services through the South Carolina

Department of Disabilities and Special Needs (SCDDSN). Waivers are mechanisms within the Medicaid Program under which, by getting the federal agency to “waive” certain generic requirements of the Medicaid program, States are able to provide services to individuals in ways not allowed under the regular Medicaid Program. This and other Waivers operated by SCDDSN are for home and community based services under Section 1915(c) of the Social Security Act [42 USC §1396n(c)]. These types of Waivers allow services to be provided in the home or community, in lieu of institutional services. The South Carolina Department of Health and Human Services (SCDHHS, Respondent) is the agency that administers the South Carolina Medicaid Program, and is responsible for the overall administration of the Waiver.

In February 2007, in anticipation of the Petitioner’s discharge home from her initial hospital stay, the Petitioner’s Service Coordinator (Ms. Gosnell, at that time) completed her Service Plan. The parties disputed several aspects of that plan including the nursing and service hours to be provided to Petitioner upon her discharge home. That dispute forms the basis of the present appeal. There are three types of services at issue in this case:

1. RN services, where a registered nurse can provide nursing care, complete certain medical tasks, and assess the Waiver Participant;
2. LPN services, where a licensed practical nurse can provide nursing care and complete certain medical tasks;
3. Attendant care services, where a qualified provider can help with activities of daily living such as light housekeeping, feeding, clothing, or bathing. Only an RN, LPN, or trained family member can provide skilled care.

In 2007, this matter was originally before the Appeals Division of the SCDHHS, but was dismissed, essentially for confusion about joinder of the issues. Thereupon, the matter was

appealed to the Administrative Law Court (ALC) which remanded the matter for an evidentiary hearing at SCDHHS. After the hearing (April 14, 2009), the SCDHHS Hearing Officer's Decision, issued on July 9, 2009, was appealed and, on July 30, 2012, the ALC once again remanded the case to the SCDHHS Appeals Division for a determination of the five issues listed below.

A hearing was held over two days: October 25, 2012 and October 31, 2012 at the SCDHHS Offices. Richard Hepfer, Esquire, represented Respondent and called as witnesses: Dr. Linda Veldheer, SCDDSN, Director, HASCI Division; Anita Atwood, SCDHHS, HASCI Waiver Administrator; Zanipha Mohammed, SCDHHS, Durable Medical Equipment; and Ashley Wingo, the Petitioner's current Service Coordinator. Patricia Harrison, Esquire, represented the Petitioner and called as witnesses: Sandra Ray, Speech Pathologist and Rhonda Galus, the Petitioner's LPN. In addition to the testimony of the witnesses, I have Declaration Statements from the Petitioner, her mother, S.W., her father, J.W., and Kathy Hoover, RN. Additionally, I have affidavits of Don Kovach of Dynavox Mayer-Johnson and Lennie Mullis.

The following documents were admitted as exhibits for the Petitioner:

1. A 9/24/2012 letter from Linda Veldheer to Petitioner indicating that, if the Petitioner approved, her services would be restored to the May 2007 levels;
2. Charles Lea Center's Estimated Annual cost of services for Petitioner for 2010, 2011, and 2012;
3. A 3/14/2007 Notice of Denial of an apparent request for additional nursing services;
4. A 3/30/2007 Notice of Denial of an apparent request for additional nursing services;
5. A 3/29/2007 Physician's Order for Petitioner for 28 hours per week of RN and 84 hours per week of LPN services, and a companion letter from Dr. Silvestri;

6. Various DDSN Manual provisions;
7. A March 18, 2010, Discharge Summary from Greenville Hospital System;
8. The Service Coordinators' Record of Contact for the Petitioner dated for various times between 12/1/09 – 09/27/12;
9. DDSN HASCI Form 15 (9-10) dated 2/22/12 by Dr. Katherine Lumpkin;
10. ICD-9 Description of the E2510 Speech Generating Device;
11. Telephone Declaration of J. W. taken by Petitioner's attorney;
12. Telephone Declaration of B. W. taken by Petitioner's attorney;
13. Telephone Declaration of S. W. taken by Petitioner's attorney;
14. Affidavit of Don Kovach;
15. Declaration of Kathy Hoover, RN;
16. Attachments to Declaration of Kathy Hoover, RN;
17. Section 2 of the Home Health Services Manual, updated 10/01/12;
18. Section 2 of the Private Rehabilitation Therapy and Audiology Services Manual, update 10/01/12;
19. An August 20, 2010, News Release from the Comptroller General's Office about the budget challenges of FY 2010;
20. A May 8, 2009, cover letter enclosing documentation about the request for the speech generating device;
21. Affidavit of Lennie Mullis;
22. Packet of documents regarding the requested speech generating device;
23. Detailed Claims Report of Petitioner dated 10/16/2012;
24. Personal Care Needs Form, no date, for B.W.;

25. DDSN Annual Accountability Report, FY 2011-2012;
26. Document entitled Head and Spinal Cord Injury (HASCI) Waiver Recommendations for Revised Service Limits, Attachment D;
27. DDSN Service Coordination Manual, Revised July 1, 2011;
28. Documents from a Nursing Services Review of Petitioner by Vivian Koon; and
29. Photographs of Petitioner.

The following documents were admitted as exhibits for the Respondent:

1. Documents related to the original request for a speech generating device; and
2. The Current HASCI Waiver document.

In addition to the exhibits listed above, the 120 page record of the 2007 attempted appeal along with the 1,582 page record of the 2009 fair hearing were also a part of the record in the current matter. Note that the undersigned Hearing Officer was new to this case in 2012 as the Hearing Officer who presided over the 2007 and 2009 matters is deceased.

### ISSUES

The Administrative Law Court has remanded this appeal to determine the following issues:

1. The weekly hours of registered nursing that are needed by the Petitioner, taking into consideration the practical scheduling concerns of qualified providers in the geographical vicinity of the Appellant.
2. The specific type of care and number of weekly hours of each type of care required by the Petitioner during the course of her treatment since her discharge from the hospital in May of 2007 consistent with the Medicaid Program, and the principle that the mother is not legally responsible for caring for the Petitioner.

3. The number of hours of the authorized care described in #2, above, that has been provided by the mother (according to her qualifications), and the cost of that care, which amount shall be paid to the mother.
4. In the future, the mother should be allowed to provide whatever care she is qualified to provide within the authorized hours of service set as described in #2, above, and shall be paid for such services at a rate to be determined upon remand.
5. The cost of an average digital speech device of the type described by Dr. Burton shall be determined and paid to the Petitioner to defray the cost of the more expensive device she purchased.

#### **HISTORY OF SERVICE HOURS DISPUTE**

The Service Plan drafted by the Petitioner's Service Coordinator in February 2007 required 28 hours per week of Personal Care Aide (PCA) services; 56 hours per week of nursing care provided by a Licensed Practical Nurse (LPN); 14 hours per week of nursing care provided by a Registered Nurse (RN). The RN services were to be evaluated after 30 days but continue in some amount per week. The care to be provided under this Service Plan totaled 98 hours per week. However, the Petitioner's treating physicians ordered 28 hours per week of RN services; 84 hours per week of LPN services for a total of 112 hours of skilled care per week. The treating physician also ordered attendant care whenever a nurse was not present. Presumably the attendant hours would be covered by the Petitioner's parents as the Petitioner's mother was the only attendant available that could provide skilled care. The Petitioner remained hospitalized as the parties continued to negotiate the Petitioner's care upon discharge. *B.W. v. SCDHHS*, Docket No. 09-ALJ-08-03440AP (S.C.A.L.C. July 30, 2012).

On March 14, 2007, DDSN issued a HASCI Notice of Denial form notifying the Petitioner that Medicaid Waiver Nursing Services were denied for exceeding service limits. "B\_\_\_ will already be receiving the maximum number of RN hours per week (44) and can not receive additional hours of LPN services according to the HASCI waiver guidelines. The HASCI waiver manual specifically states: The maximum number of nursing services/units that can be funded by the HASCI waiver is 60 hours per week provided by an LPN-OR-44 hours per week provided by an RN." Petitioner's Exhibit 3. This notice did not include any reference to a supporting statute or regulation as a basis for this decision nor did the notice provide any information regarding the continuation of benefits pending an appeal. The Petitioner was under 21 at the time this notice was issued. This notice was sent to the Petitioner's home even though she was hospitalized at this time. Although the notice cites a maximum number of nursing hours, according to the Director of the HASCI Waiver, Dr. Linda Veldheer, there were no limits under the Waiver at this time. Instead, this notice was following "HASCI Waiver procedures." T. at 60. At this time HASCI did not have caps that were part of the Waiver document but SCDDSN was following "limits we were applying at the direction of HHS." Id.

On March 29, 2007, the Petitioner's treating physician, Dr. Silvestri, ordered 84 hours per week of LPN care; 24 hours per week of RN care and attendant care at all times when the nurse was not present. On March 30, 2007, DDSN sent a denial notice stating that due to the Medicaid Waiver, the ordered Nursing Services exceeds service limits: "HASCI Waiver services (home and community based services) can not be offered when it can reasonably be expected that the cost of services to B\_\_\_ would exceed the cost of a nursing facility level of care." Petitioner's Exhibit 4. Again, no statute or regulations were cited on this notice nor was there any justification or analysis regarding whether the cost for this care would be greater than the cost of

a nursing home. Ms. Atwood testified that the Waiver limits looked at the aggregate cost of institutional vs. non-institutional care and that there were no caps applied to individuals. T. at 10-14. Dr. Veldheer testified that it would be improper for a denial to be based on the individual's service costing more than nursing home care since there are no individual limits. T. at 57. The Petitioner was under 21 at this time. This notice made no mention of continued benefits pending appeal. Like the previous notice, this notice was also sent to the Petitioner's home although she was still hospitalized at MUSC.

The notices sent to B.W. refer to limits within the HASCI Waiver. However, the Respondent presented conflicting testimony regarding whether there was in fact a limit within the HASCI Waiver at this time. According to Ms. Atwood, the HASCI Waiver Administrator for SCDHHS, there were no limits on nursing and attendant care services within the HASCI Waiver prior to July 2008. T. at 6. Dr. Veldheer asserted that SCDDSN applied limits to HASCI Waiver participants in 2007. T. at 61. Dr. Veldheer explained that, although there were no limits in the Waiver document at this time, "we were applying those kinds of limits informally." T. at 42. Dr. Veldheer claimed that in spite of the language contained in the March 30, 2007 notice, SCDDSN was not applying an individual limit. She seemed to indicate the notice is a local issue: "The service coordinator wrote this comment. I don't agree with this comment but this is what a service coordinator at the local level wrote." T. at 61. In rebuttal testimony, Dr. Veldheer contradicted her earlier statement and testified that the HASCI Waiver did not have an individual limit at the time the 2007 notices were issued. T. at 243.

On April 28, 2007, while still hospitalized, the Petitioner requested the present appeal due to the denial of the nursing and attendant care services ordered by her treating physicians. The

Petitioner was discharged on May 8, 2007, and was to receive the services that had been included in the service plan created by the Service Coordinator in February 2007.

On May 9, 2007, the day following the Petitioner's discharge from the hospital, she sent a letter to SCDDSN and SCDHHS stating she "...reserves all rights. Her acceptance of services in order to secure her release from her current, considerably more expensive institutional placement cannot be construed as a waiver, consent, limitation, estoppel, or other indication of agreement with the restrictions imposed by SCDDSN and SCDHHS." Record of 2007 Matter at 58.

In July 2008, while this appeal was pending, the Respondent reduced the Petitioner's service hours to 32 hours per week of LPN and 48 hours per week of attendant care plus seven hours per month of respite care. T. at 44. There is no notice in the record regarding this service reduction. This reduction occurred while the current appeal was pending and while the Petitioner was under 21. Dr. Veldheer testified that in July 2008, services were limited to 60 hours of LPN per week or 45 hours of RN per week or a combination not to exceed \$1,425 based on an LPN rate of \$23.75 per hour; RN rate of \$31.35 per hour. T. at 43. However, when asked about this weekly limit on cross examination, Dr. Veldheer asserts, "I never said that...We've never had weekly limits." T. at 66. According to Ms. Atwood, there were no limits on nursing services or attendant care prior to July 2008. T. at 6. The Petitioner was still not receiving RN services due to the Service Coordinator's inability to locate an RN and the mistaken idea that the RN could only provide 2 hours of care per day.

In July 2009, while this appeal was pending, the Petitioner's nursing hours were again reduced. Her LPN hours were brought down to 22 hours per week while the attendant care was increased to 48 hours per week along with 12 hours per week of respite care. T. at 45. There is

no notice in the record regarding this reduction. As with the 2008 service reductions, the 2009 reductions occurred while the current appeal was pending.

In 2010, the HASCI Waiver was renewed and an across the board cut was instituted. There was no individual assessment to determine whether the cuts were appropriate, no cost analysis to determine if less expensive services could be used, nor any medical review of the consequences of the cuts. T. at 20-21 and 25. At this time, Petitioner's services remained the same (22 hours per week LPN and 48 hours per week attendant) as the 2009 reduction had already put her services within the across the board cuts. T. at 45. According to the Respondent, since 2010, the combination of nursing and attendant care cannot exceed 70 hours per week (10 hours per day). Prior to 2010, there was a 12 hour per day limit (total limit of 84 hours per week).

In 2011, Petitioner's services went to 34 hours per week of LPN, 36 hours per week of attendant care, and 12 hours per week of respite care. This is the Petitioner's current authorization and is the Waiver limit for the combination of attendant care and nursing, according to Dr. Veldheer. T. at 45.

Prior to the hearing, the Respondent sent the Petitioner a letter offering to restore her HASCI Waiver services to the levels of May 2007 which the letter characterized as: 2-3 hours per week of RN services, 8 hours per day of LPN services, 4 hours per day of attendant care, physical therapy (P.T.), occupational therapy (O.T.), speech therapy (S.T.), and Psychological services. Petitioner's Exhibit 1. This offer totaled 83-84 hours per week of skilled and attendant care which exceeds the current waiver limits. The timing of the letter indicates that it was sent in an attempt to settle this dispute.

At some point while this appeal was pending, the Petitioner's parents divorced and the Petitioner's mother, S.W., became the Petitioner's sole caregiver.

Issues 1 and 2 will be considered together as the facts and law are inter-related.

**Issue 1 - The weekly hours of registered nursing that are needed by the Petitioner, taking into consideration the practical scheduling concerns of qualified providers in the geographical vicinity of the Appellant.**

**Issue 2 – How many weekly hours of each type of care and services have been needed by Appellant during the course of her treatment since her discharge from the hospital in May 2007 consistent with the Medicaid Program, and the principal that the mother is not legally responsible for caring for the Appellant.**

### **DISCUSSION**

At the time of the Petitioner's return home in 2007, her Service Plan called for two hours per day, seven days per week of RN care; however, the Service Coordinator was unable to find an RN in the area willing to work a two hour shift and those care hours went unfilled. As the limited daily hours appeared to be a roadblock to getting the Petitioner the RN services to which she was entitled, the Petitioner's parents asked the Service Coordinator whether they could combine the 14 hours per week so that an RN could provide services for longer periods of time over fewer days. The Service Coordinator informed the family that it was not possible to combine these nursing hours under the Waiver and that they must use two hours per day. Petitioner's Exhibit 13, Declaration of S.W. at 6. However, two witnesses for the Respondent, Ms. Atwood and Dr. Veldheer, acknowledged that Waiver participants can combine nursing hours. T. at 20 and 82. Both parties agreed that it is not possible to find an RN who would work a two hour shift. T. 199-200 and 221. Dr. Veldheer testified that because it is difficult to get an

with nursing needs will receive. T. at 226-227. The centralized nurse can determine whether a service is medically necessary. T. at 22.

Dr. Veldheer stated that if a treating physician ordered nursing hours that exceeded waiver limits, the SCDDSN centralized nurse would not give any deference to that medical order. Dr. Veldheer explained that the form used by SCDDSN does not allow the doctor to designate a recommended number of nursing hours. The doctor identifies the condition and the specific skilled nursing care they require. If the doctor ordered hours that exceeded limits, the centralized nurse would "not consider it." T. at 232.

The Respondent has not presented any medical witnesses with direct knowledge of the Petitioner's condition at either of the two hearings in this matter. The Respondent's Medical Director, Dr. Marion Burton, testified during the 2009 hearing. Dr. Burton had not met the Petitioner prior to the 2009 hearing. He was "somewhat familiar" with the case. Record of 2009 Matter at 47-48. Although Dr. Burton could not recall the specific details of the care the Petitioner was to receive upon discharge from the hospital, he believed she was to receive about 50 hours of skilled care per week and that, along with the supporting care of the parents and attendant care, was adequate to maintain the Petitioner at home. *Id.* He has no training in the treatment of head or spinal cord injuries and admitted that he was only vaguely familiar with the HASCI Waiver program. Record of 2009 Matter at 92-93. Dr. Burton admitted that he did not have the expertise to override the orders of a treating physician. His decision to deny services was based upon Department guidance and the SCDHHS provider manual policy. Record of 2009 Matter at 97, 109-111.

Tracheostomy in place – tracheoesophageal fistula

Dysphagia – GERD

Hypothyroidism

Staph coag negative bacteremia – treated with Rocephin”

Petitioner’s Exhibit 28 at 2.

The nurse’s 2011 medical record review does not indicate any improvement in the Petitioner’s condition. The nurse supported the Petitioner continuing with the ordered 22 nursing hours per week. *Id.*

According to the nurse’s 2012 report, the Petitioner’s medical diagnoses remain the same since the last review of August 9, 2011. Nurse Koon notes that the Petitioner continues to require assistance with her bowel program and supra pubic catheter care. She continues to experience urinary tract and kidney infections that require hospitalizations and experienced bilateral nephrolithiasis during a recent hospitalization. The Petitioner requires suctioning “several times day” and trach care “frequently.” The SCDDSN nurse also reported that the Petitioner requires “continued monitoring” of her skin integrity and turning to prevent decubitus ulcers. She recognized the need for medical monitoring as well as for care for anxiety, depression and seizures. Nurse Koon summarized that the Petitioner continues to require skilled care for her “multiple medical problems.” She also supported the continuation of the current authorized nursing care at 34 hours per week. Petitioner’s Exhibit 28 at 3.

Like the 2011 medical record review, the 2012 does not note any improvement in the Petitioner’s condition. In fact, the nurse has supported an increase in nursing hours by 12 hours per week. This increase in nursing hours seems to indicate that either the Petitioner’s condition

has worsened over the past year or that the previous year's 22 nursing hours per week were inadequate.

Ms. Galus testified that, on one occasion, the Petitioner's mother became ill and could not care for the Petitioner overnight. Ms. Galus stayed overnight with the Petitioner (without pay, as a favor to the family as these nursing hours offered by Ms. Galus were beyond the care that the Petitioner's Service Plan covered). Ms. Galus recounted that she was unable to sleep during the night as the Petitioner needed care every 2-3 hours including suctioning. Ms. Galus described the situation for the Petitioner and her mother as, "very, very challenging." With the exception of her mother, the Petitioner does not have good family support to help with her care. T. at 175-177. If the Petitioner's LPN is sick, there is very little substitute coverage available. Usually, there will be no substitute coverage or very little coverage on days that the LPN is out. T. at 199. Ms. Galus also testified that the Petitioner is suffering from depression and has become withdrawn. T. at 185.

Ms. Galus testified regarding the challenges surrounding Petitioner's difficulty with speaking and being understood as she cannot immediately alert her caregiver when she needs care. When she does attempt to explain her needs, it is difficult to understand as she speaks in a whisper. This communication barrier can at times delay the Petitioner getting timely care. T. at 196. The Petitioner has a whistle near her pillow which she can reach by turning her head. The whistle is used as a warning device if she is in need of care or suctioning. The Petitioner also drinks water through a straw in a cup which is also positioned within her reach by turning her head. However, if the Petitioner coughs, her arms can fly up and knock the whistle and cup out of her reach. If the Petitioner cannot reach her whistle, she could be in danger. T. at 182.

Ms. Galus testified that if the Petitioner's mother became ill, there would be no one to take care of the Petitioner. However, if the Petitioner had the hours that were ordered by her doctor (28 hours of RN and 84 hours of LPN), that would extend the Petitioner's mother's ability to care for her T. at 197-198.

The Petitioner and her mother testified via Affidavit. Although this testimony was not subject to cross examination by the Respondent; it was consistent with that of Ms. Galus in describing the Petitioner's physical condition. The Petitioner's Affidavit also provided additional details regarding her physical state including the information that she can shrug her shoulders but cannot move her body below her shoulders. The Petitioner also testified that she breathes through a trach which has to be suctioned throughout the day. She cannot breathe when she gets a mucus plug in her trach and there is no forewarning of when this will occur. Petitioner's Exhibit 12 at 3.

The Petitioner testified in the 2009 hearing that she did not want to go to a nursing home and preferred to live at home. Record of 2009 Matter at 149. Her affidavit testimony is consistent with this desire to remain in her home. She would, "rather die than go to a SCDDSN Regional Center like Whitten Center or to attend a workshop..." She also testified that she is frightened by the grand mal seizures that she has suffered. Petitioner's Exhibit 12 at 3.

I therefore find:

1. Community-based treatment is appropriate for the Petitioner and she seeks to continue community-based care.
2. The initial service plan authorized the Petitioner for 14 hours of RN services per week and required that the Petitioner's continuing need for RN services be re-evaluated after

30 days. The Petitioner's treating physician ordered 28 hours per week of RN services and 84 hours per week of LPN services.

3. The Petitioner's Service Plan also authorized 56 hours per week of LPN care and 28 hours of Attendant care.
4. The denial notices that were issued to the Petitioner prior to her initial discharge from the hospital were improper as they did not contain the statutes or regulations the actions were based upon nor did they provide instruction on how to appeal the negative action. The denial notices were sent to the Petitioner's home, although she was hospitalized at the time. Additionally, the reasons for the denials given in these notices were erroneous according to the testimony of the Respondent. The Petitioner was under 21 at the time that the denial notices were issued. The Petitioner turned 21 on January 14, 2009.
5. While pending the resolution of this appeal, the Petitioner's services were improperly reduced several times. The reductions occurred without notice and the opportunity to appeal. The reduction in 2008 occurred before the Petitioner turned 21.
6. In July 2008, the Petitioner's hours were reduced to 32 hours of LPN and 48 hours of attendant care (total of 80 hours per week). There was no notice provided to the Petitioner for this reduction.
7. In 2009, the Respondent again improperly reduced the Petitioner's service hours to 70 hours per week of combined LPN and Attendant Care. This reduction occurred during the pendency of this appeal. The Respondent again failed to provide proper notice.
8. At some point after the Petitioner was discharged from MUSC in 2007, her father moved out of the home and the Petitioner's mother became the sole family member providing

care. The Respondent should have conducted a new assessment of the Petitioner's needs when her family support was reduced to one person.

9. Upon discharge on May 9, 2007, the Petitioner was unable to find a provider of RN services willing to work the authorized hours per week and thus was unable to fill the position. The inability to locate a suitable RN was due to the Service Coordinator's erroneous assertion that the Petitioner could only receive RN hours in daily two hour increments. The Petitioner and her family relied upon this erroneous assertion. The Petitioner still has not received RN hours in her home since her initial discharge from the hospital in 2007.
10. During the pendency of this appeal, the Petitioner's mother has provided all of the care that the Respondent failed to provide due to both miscommunication and service reductions.
11. Witnesses for both parties concur that it is not possible to locate an RN who would be willing to travel to work for such a short period each day. The Petitioner and RN provider should have had the opportunity to schedule the RN hours so that the schedule best met their mutual needs.
12. The Petitioner was not re-evaluated 30 days after her initial discharge from the hospital to determine whether the 14 hours per week of RN should continue.
13. Under the current nursing hours review process, the Respondent does not seek the recommendation of the treating doctor regarding nursing hours needed by HASCI Waiver participants. The current authorization process for nursing hours requires a centralized SCDDSN nurse to perform a record review.

14. The Respondent has not provided any records which indicate that a physician for the Respondent has ever reviewed the Petitioner's medical needs.
15. The medical records review conducted by the Respondent and the testimony of witnesses for both parties indicate that the Petitioner is a quadriplegic, who relies upon a tracheostomy to breathe, and suffers from several complicated medical conditions including recurrent pneumonia, seizures, and skin break down. Due to her condition, she is at continued risk for infection. She requires constant care and cannot be left alone. Based on the testimony of witnesses for both parties, an RN should have been involved in the Petitioner's care on at least a weekly basis due to the complexity of the Petitioner's medical needs.
16. The Respondent relied upon the evaluation of a nurse to determine the hours of skilled care needed by HASCI Waiver participants.
17. An RN can assess the Petitioner's lung functioning, skin condition, and infection risks. According to the testimony of both parties, the Petitioner would benefit from a weekly assessment conducted by an RN.
18. Due to the Petitioner's complicated medical conditions and her dependence upon a single caregiver, she should receive the maximum services available under the HASCI Waiver. For this Petitioner, a four hour block of RN services is the minimum necessary per week. However, under the current rules, the Petitioner may adjust the nursing hours between RN and LPN services. The Petitioner may therefore receive up to a maximum of 45 hours per week of RN care should she so choose, bearing in mind that limit works in tandem with the limits for LPN services and an increase in RN hours may result in a

decrease in LPN hours. Current Waiver limits are 45 hours per week of RN or 60 hours per week of LPN or some combination not to exceed \$1,425 per week.

19. The Petitioner would have benefitted from 14 hours of RN care per week through June 30, 2007, and at least four 4 hours of RN services with increased RN, if the Petitioner had desired, up to the waiver limit. The Petitioner should have received RN services weekly through the present time. The Petitioner has been maintained at home with fewer services than those to which she was entitled due to the extraordinary efforts and dedication of her mother.
20. The Petitioner's benefits should have continued at the levels ordered by her treating physician during the pendency of this appeal.
21. There are RNs available in the Petitioner's service area who will cover four hours or more of care per week.

### **LEGAL DISCUSSION**

Medicaid recipients have due process rights prior to an adverse action impacting their Medicaid benefits. 42 C.F.R. § 431.200 *et seq.*; *Goldberg v. Kelly*, 397 U.S. 254 (1970). An action is defined as, "...a termination, suspension, or reduction of Medicaid eligibility or covered services." 42 C.F.R. § 431.201. Federal regulations require that the notice of adverse action must explain the action to be taken and the reason, cite the specific legal support for the action, explain the beneficiary's hearing rights, the right to representation, and the rights to continued benefits, and must be sent 10 days before an adverse action. 42 CFR §§ 431.206, 431.210, 431.211, 431.230. The regulations also require the agency to make available to the beneficiary the specific policy materials so that the beneficiary can determine whether to request a fair hearing and can prepare for the fair hearing. 42 CFR § 431.18(e).

The HASCI Waiver provides the same requirements regarding the availability of continued benefits that the federal regulations require. The HASCI Waiver Procedural Manual states that "the State may not reduce, deny or terminate services until a decision is rendered after the hearing. (For example, if the individual/legal guardian did not authorize a reduction of his/her Waiver services and the Waiver services are going to be reduced, the individual/legal guardian must be given written notice regarding the reduction which includes a 10 calendar day waiting period before the Waiver services are reduced. The Waiver services that were going to be reduced will continue as authorized prior to the request.)" SCDDSN Manual, Petitioner's Exhibit 6 at 5-7, emphasis in original. According to Dr. Veldheer, if a participant requests continuation of services, those services are continued through the Administrative Law Court level. T. at 51.

Medicaid eligible children, under age 21, are entitled to the screens and services provided by the Early and Periodic Screening Diagnostic and Treatment (EPSDT) provisions of the Medicaid law. 42 U.S.C. § 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). EPSDT requires that Medicaid children receive all of the medical services they need to diagnose, treat, or ameliorate their health needs regardless of whether these services are covered for adults in the state's Medicaid plan. 42 U.S.C. § 1396d(r)(5). The Petitioner turned 21 on January 14, 2009 and was entitled to EPSDT protections up until that time.

EPSDT, waiver services, medical necessity, and the role of the treating physician and the state's physician in determining medical necessity are all addressed in *Moore v. Reese* in which the Georgia agency was attempting to reduce the nursing hours of a disabled child in a waiver program. In that case, the Eleventh Circuit held that: (1) the State is required to provide medically necessary services to correct or ameliorate an illness or condition of a participant

under age 22 pursuant to EPSDT; (2) a state Medicaid plan must include reasonable standards for determining eligibility for and the extent of medical assistance; (3) a state may adopt a definition of medical necessity that places limits on a physician's discretion, but it must establish reasonable standards for physicians to use in determining what services are appropriate; (4) the treating physician assumes the primary responsibility of determining what treatment should be made available to his patients, but both the treating physician and the state have roles to play and a private physician's word on medical necessity is not dispositive; (5) a state may establish the amount, duration, and scope of Medicaid services, but the services must be sufficient in amount, duration, and scope to reasonably achieve the purpose of the program; (6) a state may place appropriate limits on a service based on such criteria as medical necessity by reviewing the medical necessity of treatment prescribed by a doctor on a case-by-case basis, and the State may present its own evidence of medical necessity in disputes between the state and Medicaid patients. *Moore v. Reese*, 637 F. 3d 1220, 1255 (11<sup>th</sup> Cir. 2011).

Upon remand, the Georgia District Court held that the attempted reduction in nursing hours violated the Medicaid Act. The District Court found the opinion of the treating physician was entitled much greater weight than that of the state's physician who had only reviewed the plaintiff's case on one occasion and relied on case summaries prepared by a nurse rather than reviewing the plaintiff's medical records. *Moore v. Cook*, Civ. Act. No. 1:07-CV-631-TWT, 2012 WL 1380220 (N.D. Ga. Apr. 20, 2012). *Royal v. Cook* also involved a disabled child receiving nursing services through a waiver program. In that case, the District Court found the reduction of nursing hours violated the Medicaid Act again determining that the treating physician's opinion was entitled to greater weight due to the state doctor's lack of any direct knowledge of the child's medical needs. *Royal v. Cook*, Civ. Act. No. 1:08-CV-2930-TWT,

2012 WL 2326115 (N.D. Ga. June 19, 2012). While the present case is factually similar to the *Moore* and *Royal* cases there is one significant variation. There was no live testimony provided by the Petitioner's treating physician; however, there was affidavit testimony along with orders by the treating physicians requiring nursing services.

Federal law requires that under HASCI and other such waivers, the state must spend less per capita than without the waiver. 42 U.S.C. § 1396n(e)(2)(B). The HASCI Waiver Document is clear that there is no individual cost limit. Respondent's Exhibit 2 at 24. Therefore, compliance with the federal law must be reached by looking at aggregate limits. The HASCI Waiver Document limits nursing services to 60 hours per week of LPN or 45 hours per week of RN or a combination of the two not to exceed the equivalent costs of either 60 hours of LPN or 45 hours of RN. The combination of attendant care and nursing care cannot exceed 10 hours per day. Respondent's Exhibit 2 at 1 and 85. The Waiver is not intended to provide around the clock care and the participant must rely, to a certain extent, on care provided by family or friends. T. at 47.

The Petitioner argues that the Waiver limits should not be applied to her based on *Olmstead v. Zimring*, 527 U.S. 581, 119 S.Ct. 2176. *Olmstead* held that the unnecessary institutionalization of individuals with disabilities violates the Americans with Disabilities Act. The Respondent argues that Waiver limits can be applied to the Petitioner based on *Olmstead's* "fundamental alteration" defense. "In evaluating a State's fundamental-alteration defense, the [court] must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities, and the State's obligation to mete out those services equitably." *Olmstead* at 597.

The Petitioner also cites several additional cases in support of her arguments that Waiver limits should not be applied. She argues that the *Doe* case held that an administrative agency could not apply a rule without promulgating a regulation. However, that holding was specific to the facts of that case in which a state law that was in direct conflict with the policy at issue. In this case, there is no regulation or law which conflicts with the HASCI service limits policy for adults. *Jane Doe v. SCDHHS*, 398 S.C. 62, 727 S.E.2d 605 (SC 2011).

The Petitioner argues that *Peter B. v. Sanford* prevents the Respondent from applying the Waiver reductions. *Peter B. v. Sanford*, 2011 WL 824584 (D.C.S.C. March 7, 2011). However, *Peter B.* granted a preliminary injunction preventing a reduction in Waiver services for the three Plaintiffs in that matter. A preliminary injunction is not a dispositive ruling that the potential reduction violated the ADA or *Olmstead*. It should be noted that, two years later, the matter was dismissed as moot in the case of two of the three plaintiffs due to no actual reduction in their Waiver services. Again, the court did not find that Waiver reductions violated the ADA or *Olmstead*. *Peter B. v. Sanford*, 2013 WL 869607 (D.C.S.C. March 7, 2013).

### **CONCLUSIONS OF LAW**

1. At the time of the appeal, the Petitioner was still hospitalized. The Respondent had denied the service hours ordered by the Petitioner's treating physician and approved a Plan of Care which provided fewer hours. The Petitioner was appealing her dispute over the decreased hours approved by the Respondent in the Plan of Care. One day after discharge, the Petitioner wrote to the Respondent to "reserve all rights." Although the subsequent reductions in service hours which the Petitioner faced were not known at the time of the letter, it is reasonable to assume her request to reserve her rights indicated that she sought continued benefits in the event of future service reductions. The skilled care

ordered by her treating physician at the time of her discharge from the hospital (28 hours per week of RN and 84 hours per week of LPN) should have continued throughout this matter. The Respondent violated the Petitioner's due process rights in enforcing its waiver reductions against her during the pending appeal. Because of the due process violations, it is unnecessary to determine whether the Respondent has given agency rules the weight of a promulgated regulation when the reductions were applied to her.

2. While under the age of 21, the Petitioner was entitled to the protections afforded by EPSDT including deference to the orders of her treating physicians regarding medically necessary services while recognizing that the Respondent can impose reasonable limits on the treating physicians' orders. There has been no testimony by the Petitioner's physician that has been subject to cross examination. However, the initial order of the treating physician was issued during the Petitioner's lengthy hospital stay and was supported by a treating physician's order two years later. The Petitioner offered into evidence contemporaneous orders and affidavits from her treating physicians stating that 28 hours per week of RN services were medically necessary. The testimony provided by the Respondent's Medical Director showed a lack of first-hand knowledge of the Petitioner's medical needs. The recommendations of the Respondent's physician were based on the Petitioner receiving about 50 hours of nursing care per week (an amount which she has not received since 2008) along with the assumption that both parents were providing supporting care to the Petitioner. The Respondent has not provided any record of a medical examination of the Petitioner's needs 30 days after her discharge from the hospital. Nor did the Respondent provide any record of a medical examination at the 2009 or the 2012 hearings. It appears as though the Respondent has not conducted a

medical examination of the Petitioner at any time during the pendency of this appeal. The Petitioner should not have been subject to Waiver limits for skilled care services while under the age of 21 and should have received 28 hours per week of RN and 84 hours per week of LPN as ordered by her treating physician. These hours should have continued through the final result of this appeal.

3. Due to the complicated medical needs and fragile condition of the Petitioner, it appears as though her medical needs could exceed Waiver limits. The Petitioner argues that she should not be subject to the HASCI Waiver limits based on the cases cited above. However, these cases are distinguishable from the present case. The Respondent's September 2012 settlement letter implicitly acknowledges that it may be appropriate to exceed Waiver limits for this particular participant; however, an Administrative Hearing Officer does not have the authority to exceed the limits of the Waiver program. Since reaching the age of 21 and after the conclusion of this appeal, the Petitioner can be subject to Waiver limits and I so order.
4. Should the Petitioner experience a change in circumstances, including a worsening of her condition, she can seek additional service beyond the Waiver limits. Should she experience a service reduction, the Respondent shall provide notice and an opportunity for a hearing.

**Issue 3 – How many hours of the authorized care described in #2 above, have been provided by the Petitioner's mother (according to her qualifications), and what is the cost of that care, which amount shall be paid to the Petitioner's mother.**

In 2007, SCDDSN Service Coordinator told the Petitioner's mother that SCDDSN rules prohibited the Petitioner's mother from being paid for services she provided to the Petitioner

even though the Petitioner was an adult at this time. The Petitioner's mother should be reimbursed for the number of hours per week that should have been in effect based on continuation of benefits pending the final outcome of the 2007 appeal. The parties failed to provide sufficient evidence for me to determine when the Petitioner was hospitalized and how long each inpatient hospitalization lasted; therefore, I have determined that the Petitioner's mother should be paid for the hours of care provided through the first week in October, 2013 at the rate of \$11.10 per hour. The services she has provided since then until the date of this decision will offset the instances she was not providing attendant care while the Petitioner was hospitalized.

I therefore find:

1. Based on the testimony of both parties, it appears that the Petitioner's mother provided most, if not all, of the uncovered care for the Petitioner from the time she returned home until the present.
2. A family member of a Waiver participant can be paid for authorized hours of attendant care. The Petitioner's mother qualifies as an attendant caregiver.
3. The Petitioner's mother has not been compensated for the care she has provided to the Petitioner.
4. The number of Waiver and State Plan covered hours per week should have amounted to 112 hours as ordered by the Petitioner's treating physician while she was under the age of 21 and protected by the EPSDT provisions of the Medicaid program. This initial amount of ordered care should have continued during the pendency of this appeal.
5. On January 14, 2006, while still hospitalized, the Petitioner turned 18 years of age. As an adult, her parents were no longer legally responsible for her.

6. The Petitioner's mother provided attendant care services to the Petitioner. The parties are in agreement that the current payment rate for Attendant Care is \$11.10.
7. The Petitioner's mother is entitled to reimbursement for the care that she provided as follows:

**Hours for Which Petitioner's Mother Shall Be Compensated**

| Year         | Weeks | Hours Res. Should have Provided | Actual Hours Provided by Res. | Hours Provided by S.W. | Weeks x Hours Provided by S.W. | Amount Owed to S.W. at \$11.10 hour |
|--------------|-------|---------------------------------|-------------------------------|------------------------|--------------------------------|-------------------------------------|
| 2007         | 33    | 112                             | 84                            | 28                     | 924                            | \$ 10,256.40                        |
| 2008         | 27    | 112                             | 84                            | 28                     | 756                            | \$ 8,391.60                         |
| 2008         | 25    | 112                             | 80                            | 32                     | 800                            | \$ 8,880.00                         |
| 2009         | 27    | 112                             | 80                            | 32                     | 864                            | \$ 9,590.40                         |
| 2009         | 25    | 112                             | 70                            | 42                     | 1050                           | \$ 11,655.00                        |
| 2010         | 52    | 112                             | 70                            | 42                     | 2184                           | \$ 24,242.40                        |
| 2011         | 52    | 112                             | 70                            | 42                     | 2184                           | \$ 24,242.40                        |
| 2012         | 52    | 112                             | 70                            | 42                     | 2184                           | \$ 24,242.40                        |
| 2013         | 40    | 112                             | 70                            | 42                     | 1680                           | \$ 18,648.00                        |
| <b>TOTAL</b> |       |                                 |                               |                        |                                | <b>\$ 140,148.60</b>                |

**CONCLUSIONS OF LAW**

1. At all times during this appeal the Waiver provisions allowed the parents of adult children to serve as paid caregivers to those children according to their training and qualifications (Record of the 2009 Matter at 766.)
2. The rate specified for attendant care providers under the Waiver at all times during this appeal has been \$11.10.
3. The Petitioner's mother shall be reimbursed by the Respondent in the amount of \$140,148.60 for the care that she provided. The Respondent shall reimburse the Petitioner's mother within 30 days of the date of this Order.

**Issue 4 – What care is the Petitioner’s mother qualified to provide within the authorized hours of service set as described in #2 above and what is the appropriate rate of pay to the Petitioner’s mother?**

### **DISCUSSION**

Due to the miscommunications described above between the parties, the Petitioner’s mother, was not aware that she could be reimbursed for the care that she has provided for the Petitioner. During the Petitioner’s lengthy hospital stay, the Petitioner’s mother learned to provide suctioning, trach care, and catheter care for the Petitioner. Petitioner’s Exhibit 13 at 3. This is skilled level care that only a nurse can provide. Even though the Petitioner’s mother does not have any formal medical training, she can provide skilled care for her daughter as a close family member and caregiver. Since the Petitioner’s mother has not trained as a nurse, the care she provides is viewed as attendant care services. The parties are in agreement that the Petitioner’s mother should be compensated at the attendant care rate of \$11.10 per hour for the services that she provides to the Petitioner when a nurse is not present. I therefore find:

1. The Petitioner’s mother is qualified to provide skilled care and attendant care services to B.W. The Petitioner’s mother has provided skilled and attendant care during the course of this appeal.
2. The current rate for attendant care providers is currently \$11.10 per hour.
3. The pay rate for attendant care may be subject to change in the future.

### **CONCLUSIONS OF LAW**

1. Petitioner’s mother shall be paid at the rate allowed for attendant care providers which is currently \$11.10 per hour.

2. Changes to the pay rate which impact other attendant care providers will also be applied to the Petitioner's mother.
3. Whether the Petitioner's mother must be formally enrolled as a SCDDSN provider is irrelevant to my decision. However, should enrollment be requested by the Respondent in order to ensure timely payment to the Petitioner's mother, the Petitioner's mother shall be afforded all assistance necessary to hasten her enrollment as a SCDDSN provider. Any enrollment process that may be requested shall not prevent the Petitioner's mother from receiving reimbursement for services previously and currently provided.

**Issue 5 – What is the cost of an average digital speech device to be paid to the Appellant to defray the cost of the device she purchased?**

### **DISCUSSION**

The Petitioner is unable to speak effectively due to injuries to her larynx subsequent to the automobile accident which rendered her quadriplegic. In January 2007, while at MUSC, she was evaluated for a speech generating device and the device was ordered by her physician at the hospital. The device was subject to a prior authorization review by the Medical Director of SCDHHS who found that a less expensive device was appropriate. In March 2007, the Respondent sent a notice that the prior authorization could not be processed stating: "Per our medical consultant, this is not medically necessary or rehabilitative." Petitioner's Exhibit 22. The notice was sent to the durable medical equipment (DME) provider, not the Petitioner. The notice did not state a statute or regulation upon which the decision was based nor did it provide any information regarding the Petitioner's right to appeal the decision. On April 12, 2007, the SCDDSN Service Coordinator wrote to the Petitioner's attorney stating that the HASCI Waiver will pay for assistive technology for the Petitioner once she comes home. Exhibit 3 to

Petitioner's Exhibit 12 (Affidavit of B.W.). On April 24, 2007, Dr. Teresa Cuoco ordered an alternative speech generating device for the Petitioner. On April 25, 2007, Dr. Pamela Pride signed the certificate of medical necessity for this speech generating device. On May 21, 2007, the Respondent notified the DME provider, Dynavox, that the prior authorization request would not be processed. Again, the Respondent informed only the DME provider and not the Petitioner. As with the previous notice, this notice did not state a statute or regulation upon which the decision was rendered nor did the notice provide any information regarding the Petitioner's right to appeal the decision. The Petitioner was under 21 at the time that her treating physicians ordered the speech generating devices and was subject to the protections of EPSDT which allowed her to receive treatment to correct or ameliorate defects and physical illnesses. 42 U.S.C. 1396d(r)(5). According to the Respondent's witness, Ms. Mohamed, the Medicaid program covers speech augmentative devices and covered the particular device that was ordered by the Petitioner's doctor. T. at 119. The entire package of the speech generating device and the covered attachments would have cost the Respondent, "a little over \$8,000." T. at 125. In 2008, after the delays and miscommunications noted above, the Petitioner purchased a speech generating device herself at a cost of \$12,217.70.

The Petitioner testified, via affidavit, that she is frustrated by her inability to communicate which has isolated her and contributed to her depression. Petitioner's Exhibit 12. Ms. Galus, testified that the Petitioner's current speech device requires her to attach a small metal disk to her forehead to use the device. The Petitioner has become allergic to the adhesive used to attach the disk to her forehead. Ms. Galus further testified that the Petitioner is unable to wear her eye glasses when using the device which causes her to suffer migraine headaches. The migraines and the allergies limit the amount of time the Petitioner can use the speech device.

Witnesses for the Petitioner testified that it is possible to obtain speech generating devices which utilize eye gaze technology and do not require an adhesive dot to be attached to the individual's forehead. The Respondent's witness, Ms. Mohammed, testified that there was no set schedule of how often replacement speech devices can be authorized. Authorization of a new device depends on medical necessity. T.at 132. Ms. Wingo, the current Service Coordinator, was also questioned regarding the Petitioner's need for a replacement communication device, to which she responded, "that's outside my scope of job – outside my job description." T at 115.

As the Respondent would have approved a less expensive speech generating device, the Administrative Law Court has determined that the Respondent pay the Petitioner the amount that would have been paid for a digital device in order to defray the cost of the device that the Petitioner purchased. I therefore find:

1. The Petitioner was eligible to receive a speech generating device at the time her doctor ordered it and the Medicaid program covered such devices.
2. A speech generating device and the covered attachments that would have met the Petitioner's needs and her doctor's order would have cost slightly more than \$8,000.00.
3. The Respondent has offered to pay the Petitioner \$8,318.80 to defray the cost of the speech generating device that was purchased by the Petitioner outside of the Medicaid program.
4. The offer of \$8,318.80 is fair based upon the types of devices and attachments covered by the Respondent. This offer is consistent with the cost of such devices and attachments.

#### **CONCLUSIONS OF LAW**

1. The Petitioner's mother shall be reimbursed \$8,318.80 to defray the cost of the speech device which she purchased.

2. The Respondent shall reimburse the Petitioner's mother within 30 days of the date of this Order.
3. Whether the cost of the device is covered by the Waiver or by the State Plan is irrelevant to my decision and shall be determined by the Respondent and its agent, SCDDSN. That determination shall not impact or delay the reimbursement of the \$8,318.80 owed to the Petitioner's mother.
4. This Order does not prevent the Petitioner from seeking the difference between the amount awarded here and the actual cost her family incurred. Nor does this Order prevent the Petitioner from seeking an assessment for a new speech generating device or a replacement speech generating device in the future. Should a future medical order for a speech generating device by the Petitioner's provider be denied or reduced by the Respondent, the Respondent shall send the Petitioner notice of such denial or reduction allowing the Petitioner the opportunity to appeal.

#### **DECISION**

1. The Petitioner shall receive RN, LPN, and Attendant Care services to the extent allowable under HASCI Waiver limits. She may receive 45 hours per week of RN or 60 hours per week of LPN or a combination of the two not to exceed the costs of RN care. She may combine attendant care with these hours to receive a maximum of 10 hours of nursing and attendant care per day. The Petitioner shall determine the mix of services she shall receive and those hours shall be flexible depending on her needs and the availability of providers in her area. The Service Coordinator shall assist the Petitioner in securing these services.

2. The Petitioner's mother may provide some of the hours of care required under the Petitioner's Service Plan. If the Petitioner's mother provides such care, she shall be paid for that care at the rate for Attendant Care Services (currently \$11.10 per hour).
3. The Petitioner's mother shall be repaid in the amount of \$140,148.60 for the care she provided to the Petitioner during the pendency of this appeal. This amount shall be paid to the Petitioner's mother within 30 days of the date of this Order.
4. Within 30 days of the date of this Order, the Respondent shall reimburse the Petitioner's mother \$8,318.80 for the cost of the speech generating device.

Any issues not addressed in this Order are deemed dismissed.

**AND IT IS SO ORDERED.**

  
Elizabeth B. Hutto  
Hearing Officer

DATED AT COLUMBIA,  
South Carolina

November 19, 2013

# Exhibit 4

December 23, 2013 order of DHHS hearing officer in B.W. v. DHHS

Nikki Haley GOVERNOR  
Anthony Keck DIRECTOR  
P.O. Box 8206 > Columbia, SC 29202  
[www.scdhhs.gov](http://www.scdhhs.gov)

December 23, 2013

Patricia Harrison, Esquire  
611 Holly Street  
Columbia SC 29205  
**VIA CERTIFIED MAIL**

Richard G. Hepfer  
Deputy General Counsel  
South Carolina Department of Health and Human Services  
**VIA ELECTRONIC DELIVERY**

RE: Order in Response to Respondent's Motion for Reconsideration  
Matter of Brook Waddle v. SCDHHS  
Appeals' Case # 07-MISC-028  
Medicaid # 6780499394

Dear Ms. Harrison and Mr. Hepfer:

Enclosed, please find the Order in Response to Respondent's Motion for Reconsideration in the above-referenced matter.

Sincerely,



Elizabeth B. Hutto  
Program Director, Division of Appeals and Third Party Liability  
Interim CFO, SCDHHS

EBH/ss  
Enclosures (2)

|                                     |   |                                |
|-------------------------------------|---|--------------------------------|
| STATE OF SOUTH CAROLINA             | ) | BEFORE THE DIVISION OF         |
|                                     | ) | APPEALS AND HEARINGS           |
| COUNTY OF RICHLAND                  | ) | SOUTH CAROLINA DEPARTMENT OF   |
|                                     | ) | HEALTH AND HUMAN SERVICES      |
| B.W.,                               | ) |                                |
|                                     | ) |                                |
| Petitioner,                         | ) | <b>ORDER</b>                   |
|                                     | ) | <b>RESPONDENT'S MOTION FOR</b> |
| -v-                                 | ) | <b>RECONSIDERATION</b>         |
|                                     | ) |                                |
| South Carolina Department of Health | ) |                                |
| and Human Services,                 | ) | Appeals' Case #: 07-MISC-028   |
|                                     | ) | (Remanded)                     |
| Respondent.                         | ) |                                |
| _____                               | ) |                                |

### BACKGROUND

On November 19, 2013, the Final Administrative Decision was issued in this matter. The history of this case was described therein. In response, the Respondent filed a Motion for Reconsideration on December 2, 2013. As of the undersigned date, the Petitioner has failed to respond to the Respondent's Motion.<sup>1</sup> In essence, the Respondent asserts error in the conclusion of law that the Petitioner was entitled to continued benefits at the level that her physicians ordered during the pendency of this appeal. The Respondent makes three requests for relief of the undersigned Hearing Officer as follows:

- "1. Correct the erroneous conclusion of law that when a denial of services is appealed, that the denied services must continue until a decision is rendered on the appeal;
2. Consequently find that, in this case, the appeal, and therefore the requirement to maintain services, did not initially apply to the reductions in services; and
3. Therefore, that under Judge McLeod's directions in this matter that the formally published Waiver limitations (not the ones informally applied by the Departments) should be used to determine the amount of the waiver services that should have been provided since discharge from the hospital."

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<sup>1</sup> Note, on December 16, 2013, an email from the Petitioner's Attorney was received by the undersigned Hearing Officer. In that email, the Attorney for the Petitioner explained that, "[M]y assistant of 20 years retired recently and Rick's motion appears to have been misfiled in my office." An email sent two days later clarified that the legal assistant had retired in September.

(Respondent's Motion for Reconsideration at 4)

### DISCUSSION

The Respondent asserts that the Final Administrative Decision errs by interpreting 42 C.F.R. § 431.230 as applying to a denial when the language in the regulation speaks only of terminations or reductions of services. I disagree with the assertion that the regulation has been misinterpreted.

In this case, the Petitioner, as advised by her treating physicians stated she needs 112 hours of total care per week. The Respondent, despite not visiting or examining the Petitioner, insisted on fewer hours of skilled care and denied the request for 112 total hours even though this would have been sharply less than the round-the-clock RN hours received during the initial hospitalization that lasted for approximately a year and a half. After many months of delays, the Petitioner was forced to accept the Respondent's proposed hours if she wanted to return home. There was no viable alternative. The Respondent's assertion that this appeal is about a denial of services does not hold up. Clearly, the dispute is over a reduction of services.

In their first request for relief, the Respondent seems to express concern that the asserted misinterpretation of 42 C.F.R. § 431.230 would allow every Medicaid beneficiary who requests a "new service," and who appealed, to receive the service until a hearing decision could be rendered on his request. I believe this concern is misplaced for the reasons stated above. There was never any question that the Petitioner was entitled to, and needed, skilled nursing care. Skilled nursing care was not a "new service" for this Petitioner.

The Respondent's second request that the waiver limits be applied to the Petitioner during the pendency of this appeal cannot be realized due to the Respondent's failure to provide adequate notice of any of the reductions that were applied to the Petitioner. This failure violated the Petitioner's due process rights. When a recipient requests a hearing, the agency may not

terminate or reduce services until a decision is rendered after the hearing unless the agency “promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision.” 42 CFR §431.232 (emphasis added). Finally, the hearing must cover “agency decisions regarding the type or amount of services.” 42 CFR §431.241 (emphasis added). Even if the Respondent had the discretion to subject the Petitioner to service reductions during the pendency of this appeal, the facts bear out that reductions were executed without prior written notice. These reductions were improper because they violated the Petitioner’s due process rights.

The Respondent’s third request is based upon an interpretation of the language in the second issue articulated in the July 30, 2012 Remand of the Administrative Law Court. That issue stated:

“The specific type of care and number of weekly hours of each type of care required by the Petitioner during the course of her treatment since her discharge from the hospital in May of 2007 consistent with the Medicaid Program, and the principle that the mother is not legally responsible for caring for the Petitioner.”

The Respondent argues that Judge McLeod’s language “consistent with the Medicaid Program,” means “within the formal waiver limits.” I disagree. It seems that had the Administrative Law Judge intended that the formal waiver limits should have applied throughout the appeal, that specific language would have been used. It appears more likely that, “consistent with the Medicaid Program,” refers to due process, the delivery of medically necessary services, EPSDT protections, and all other state and federal requirements of Medicaid program.

**ORDER**

For the foregoing reasons, the Respondent's Request for Reconsideration is hereby denied. The Final Administrative Decision of November 19, 2013 stands.

**AND IT IS SO ORDERED.**

*Elizabeth B. Hutto*

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Elizabeth B. Hutto  
Hearing Officer

DATED AT COLUMBIA,  
South Carolina

December 23, 2013

# Exhibit 5

Appellant's Response to Order

**In the Office of Hearings and Appeals of  
the South Carolina Department of Health and Human Services**

**RECEIVED**

Fair Hearing of Brook Waddle v. DHHS

MAR 22 2013

Case No. 12-MISC-021 (MR/RD Waiver)

**SCDHHS APPEALS**

**Appellant's Response to Order**

Federal regulations contained at 431.243 provide that hearing decisions must be based exclusively on evidence introduced at the hearing and that a final determination must be issued within 90 days from the date the participant requested a fair hearing. Appellant has alleged that DHHS is in violation of federal regulations and has requested a fair hearing. An appeal may not be dismissed unless the appellant requests dismissal or fails to appear at a scheduled hearing without good cause.

The Appellant asserts that DHHS improperly denied equipment, supplies and services that are medically necessary. The agency has violated the requirements of the Medicaid Act that require DHHS to provide services in the amount, duration and scope necessary to prevent hospitalization and/or to delay or prevent institutionalization, that the agency has violated the reasonable promptness requirements of the Medicaid Act and that the failure to provide an appropriate speech device has prevented Appellant from communicating effectively with providers of health care and her attorney. All allegations previously made by Appellant during the course of these proceedings and the appeal filed in 2007 are herein realleged. In addition, DHHS has violated the Americans with Disabilities Act and the Rehabilitation Act of 1973 by failing to provide services necessary for Appellant to remain in the community and, thereby, placing her at risk of institutionalization. Respondent has violated the South Carolina

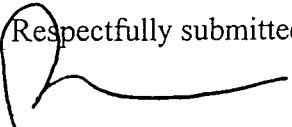
Administrative Procedures Act by failing to promulgate regulations for the operation of Home and Community Based Waiver programs.

Appellant filed an appeal in 2007, which has been remanded to this Office by the South Carolina Administrative Law Court twice, most recently in July of 2012. Six years has passed since this request for services was filed and seven months has passed since DHHS was ordered to comply with the findings of the South Carolina Administrative Law Court. During this appeal, in violation of its own policies, DHHS reduced the hours that have been ordered by Appellant's physicians and the agency has refused to pay Appellant for services provided by her mother or for the speech device her physicians determined to be medically necessary. An emergency motion was filed by Appellant in December, 2012, but no final order has been issued by the DHHS Office of Hearings and Appeals. Appellant's rights to due process have hence been violated and this violation is subject to repetition, yet it has evaded review. This refusal to comply with the Order of the Administrative Law Court, the Americans with Disabilities Act and the Medicaid Act has demonstrated conscious indifference of DHHS and its officials to the risks of harm to Appellant and the decline in her medical and psychological condition.

Furthermore, Appellant alleges that the agency has violated her due process rights by requiring her to attend any hearings in Columbia, by refusing to pay travel costs and costs of experts and by requiring Appellant to comply with requirements that are in excess of those contained in 42 C.F.R. 431 et. seq. Appellant requests that this Court provide reasonable accommodations to Appellant, as a person with a communications disability, as required by the Americans with Disabilities Act to enable Appellant to allow her to participate effectively in appeals before DHHS. Appellant requires adaptive equipment to enable her to understand and to be understood in any these proceedings.

This hearing involves medical issues concerning the needs of the Appellant, who requests the appointment of an independent medical assessment at the expense of the State, with this assessment to be scheduled at a time convenient to Appellant and her counsel. This response is being provided to the DHHS Office of Hearings and Appeals by email and regular mail.

Respectfully submitted,



Patricia L. Harrison  
611 Holly Street  
Columbia, South Carolina 29205  
[plh.cola@att.net](mailto:plh.cola@att.net)  
803 256 2017

March 19, 2013

IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

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Case No. 2013-002415

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Brook Waddle,

Appellant,

v

South Carolina Department of Health  
and Human Services,

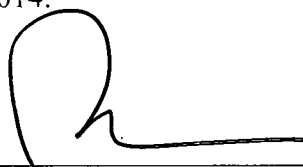
Respondent.

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CERTIFICATE OF SERVICE

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Patricia L. Harrison certifies that she has served *Appellant's Response to Respondent's Motion to Strike* in the above captioned case on the Respondent by United States mail to the Office of General Counsel, SC Department of Health and Human Services, PO Box 8206, Columbia, SC 29202-8206 on March 24, 2014.



---

Patricia L. Harrison  
611 Holly Street  
Columbia, South Carolina 29205  
(803) 256-2017

RECEIVED

MAR 27 2014

SC Court of Appeals