

IN THE STATE OF SOUTH CAROLINA

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In the Court of Appeals

SC Court of Appeals

APPEAL FROM THE SOUTH CAROLINA

Administrative Law Court

Ralph K. Anderson, III, Chief Administrative Law Judge

Appellate Case No. 2013-002415

Brook Waddle; Appellant,

v.

South Carolina Department of Health and Human Services Respondent.

RECORD ON APPEAL

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ATTORNEY FOR APPELLANT

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INDEX TO RECORD ON APPEAL

ORDERS

ALC Order dated October 11, 2013	2
DHHS Order of Dismissal in the Appeal dated April 4, 2013	10
DHHS Order dated November 19, 2012	14
DHHS Order dated December 23, 2013	54

NOTICES OF APPEAL

Notice of Appeal from DHHS to ALC dated May 9, 2013	58
Notice of Appeal from ALC to SC Court of Appeals dated November 11, 2013	60

MOTIONS AND RESPONSE

Respondent's Motion to Dismiss dated November 24, 2014	61
w/ Affidavit in Support of Respondent's Motion to Dismiss	
Respondent's Motion to Dismiss dated September 11, 2013	67
Appellant's Reply to Motion to Dismiss dated September 23, 2013	73

BRIEFS

Appellant's Initial Brief to ALC dated August 13, 2013	74
Respondent's Brief dated September 11, 2013	112
Appellant's Amended Reply Brief dated September 25, 2013 (typo "2017")	132

RECORD ON APPEAL TO ALC

Record on Appeal filed in ALC (Prepared by DHHS Office of Hearings and Appeals)	144
Order Dismissing Appeal dated April 4, 2013	147
Emails	149
Appellant's Response to Order dated March 19, 2013	152
Letter from Counsel for DHHS to Hearing Officer dated March 19, 2013	155
PreHearing Conference Order dated February 5, 2013	158
Request for Fair Hearing dated January 30, 2013	159
"Notice of Denial" dated January 14, 2013	160

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Brook Waddle,	)	Docket No. 13-ALJ-08-0267-AP
	)	
Appellant,	)	
	)	
vs.	)	ORDER
	)	
South Carolina Department of Health and	)	
Human Services,	)	
	)	
Respondent.	)	
_____	)	

STATEMENT OF THE CASE

This matter comes before the South Carolina Administrative Law Court (ALC or Court) pursuant to Appellant Brook Waddle's (Appellant) appeal from the April 4, 2013 dismissal by the South Carolina Department of Health and Human Services (HHS) of Appellant's case. The HHS hearing officer dismissed Appellant's appeal, considering it abandoned, for failure to respond to the hearing officer's order for Appellant to provide a statement of her intention to continue with the appeal by the given date.¹ For the reasons set forth below, I hereby deny the HHS' motion to dismiss this case, in whole or in part, pursuant to Rules 33 and 38 of the South Carolina Administrative Court Rules (SCALCR) and Rules 12(b)(1) and (8) of the South Carolina Rules of Civil Procedure (SCRCP), but affirm the decision of the hearing officer.

BACKGROUND

Appellant was injured in an automobile accident in 2005, which rendered her quadriplegic. She became eligible for Medicaid-covered services, and has been receiving services under the South Carolina Head and Spinal Cord Injury (HASCI) Waiver. Waivers are mechanisms within the Medicaid program under which the federal HHS waives certain generic

¹ The original deadline to submit this information was March 19, 2013, as set forth in the hearing officer's Prehearing Conference Order dated February 5, 2013. However, the hearing officer, upon receiving Appellant's Response to the Prehearing Conference Order, filed March 22, 2013, informed Appellant via email dated March 27, 2013 that Appellant's response "did not address the issue in [her] case (denial of prior authorization of an oximeter cable for [Appellant])" and instructed her "to include with [her] response the documentation of medical necessity for the cable[.]" and therefore extended the due date until Tuesday, April 2, 2013. Appellant did not respond as of the date of the hearing officer's dismissal Order (April 4, 2013).

FILED

October 11, 2013

SC ADMIN. LAW COURT

requirements of the Medicaid program, allowing States to provide services to individuals in ways not allowed under the regular Medicaid program. Though the Department of Disabilities and Special Needs (DSN) is responsible for the day-to-day operation of the waiver, HHS is the agency that administers the South Carolina Medicaid program and thus the overall waiver program. This waiver, among others, is for home and community-based services under 42 U.S.C. § 1396n(c), allowing for services to be provided in the home rather than an institution.

Apria Healthcare, Inc. (Apria), a provider of medical equipment, submitted to KePro, the agent of HHS, a prior authorization request on behalf of Appellant for medical equipment, specifically an oximeter cable.² However, KePro denied Apria's request because Apria did not provide any supporting clinical information with its request. KePro gave Apria forty-eight (48) hours to submit supporting clinical information and a prescription for the device, but Apria failed to do so. Consequently, Apria's request was denied administratively for failure to supply the necessary information to allow KePro to make a determination.

Both Appellant and HHS tried to resolve the issue with KePro and/or Apria, but to no avail. Indeed, HHS even asked Apria to resubmit its request with supporting documentation, but the issue remains pending.³

On January 31, 2013, Appellant filed an appeal of KePro's denial of Apria's request with HHS' Division of Appeals and Hearings. On February 5, 2013, the HHS hearing officer issued a Prehearing Conference Order requiring HHS "to submit [by March 19, 2013] a summary of issues discussed, whether consensus was reached and any remaining issues." HHS' summary was to identify, with specificity, any additional information that [would] be submitted at the hearing or requests that either party anticipate[d] making." In the same order, Appellant was instructed "to submit a statement of intention to continue the appeal process and attend a Fair Hearing." Both Appellant and HHS responded to the hearing officer's order on March 19, 2013. However, Appellant erroneously emailed her response to Beth Hutto, who at the time was the director of HHS's Division of Appeals and Hearings and Third Party Liability;⁴ Byron Roberts, HHS' general counsel; Janet Goode, the hearing officer in one of Appellant's prior appeals; and

² An oximeter measures the oxygen saturation level of the blood.

³ This is as of March 19, 2013, and there is nothing in the Record on Appeal to indicate that the issue has since been resolved.

⁴ Hutto is currently the interim CFO for HHS.

to two other, unnamed individuals.⁵ Hutto forwarded the email to the proper hearing officer, Renee Johnson, who responded on March 27, 2013 by informing Appellant that her response did not “address the issue of my case (denial of prior authorization of an oximeter cable for BW)” and that Appellant needed to “include with [her] response the documentation of medical necessity for the cable.” The hearing officer also extended the due date until April 2, 2013. Appellant did not respond.

On April 4, 2013, the hearing officer issued an order dismissing Appellant’s appeal on the ground that Appellant abandoned her appeal by failing to provide a statement by the given deadline (April 2, 2013) of her intention to continue with the appeal process and attend a Fair Hearing.

Appellant filed an appeal of that decision with the ALC. Appellant served HHS with the Notice of Appeal on May 9, 2013 but erroneously filed the Notice of Appeal with the Court of Appeals before the Court of Appeals forwarded it to the ALC, which date stamped its receipt on June 11, 2013.

ISSUE ON APPEAL

Whether it was arbitrary or capricious for the hearing officer to dismiss Appellant’s case based on the grounds that Appellant abandoned her appeal by failing to provide a statement by the given deadline of her intention to continue with the appeal process and attend a Fair Hearing.⁶

STANDARD OF REVIEW

This case is before the ALC as an appeal of an agency decision. Accordingly, the standard used by appellate bodies to review agency decisions is provided by Section 1-23-380(5) of the South Carolina Code (Supp. 2012). That section states:

The court may not substitute its judgment for the judgment of the agency as to the weight of the evidence on questions of fact. The court may affirm the decision of the agency or remand the case for further proceedings. The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:

(a) in violation of constitutional or statutory provisions;

⁵ kanthony@anthonylaw.com and tippybrook@yahoo.com were the two unnamed addressees cc’d on the email.

⁶ Appellant listed five issues on appeal in her Brief and HHS listed four issues on appeal in its Brief. However, the Court concludes that the lone issue stated above is sufficient to properly dispose of this case. In addressing this issue, though, one or more of the parties’ issues may be addressed, either directly or by implication.

- (b) in excess of the statutory authority of the agency;
- (c) made upon unlawful procedure;
- (d) affected by other error of law;
- (e) clearly erroneous in view of the reliable, probative and substantial evidence on the whole record; or
- (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

§ 1-23-380(5); *see also* § 1-23-600(E) (directing administrative law judges to conduct appellate review in the same manner prescribed in § 1-23-380).

“A decision is arbitrary if it is without a rational basis, is based alone on one's will and not upon any course of reasoning and exercise of judgment, is made at pleasure, without adequate determining principles, or is governed by no fixed rules or standards.” *Trimmier v. S.C. Dep't of Labor, Licensing and Regulation*, 405 S.C. 239, 746 S.E.2d 491 (Ct. App. 2013) (quoting *Deese v. S.C. State Bd. of Dentistry*, 286 S.C. 182, 184–85, 332 S.E.2d 539, 541 (Ct.App.1985)).

DISCUSSION

Respondent's Motion to Dismiss

As a preliminary matter, the Court must address HHS's Motion to Dismiss or, in the Alternative, Partial Motion to Dismiss filed September 11, 2013. Pursuant to Rule 38, SCALCR and Rules 12(b)(1) and (8), SCRCP, HHS moves to dismiss Appellant's appeal on the following grounds: (1) Appellant failed to file a timely Notice of Appeal; (2) lack of jurisdiction due to Appellant's failure to file her Notice of Appeal timely; and (3) Appellant is attempting to relitigate in this proceeding the same or substantially the same issues raised in a pending proceeding between the same parties. In the alternative, HHS moves to dismiss all of Appellant's claims except for the claim pertaining to the denial of the oximeter cable, should the Court find that the oximeter cable issue was not substantially the same as claims arising in the prior proceedings. I will address each ground, in turn, but will consolidate the first two grounds and then the third and alternative grounds, as they are respectively interrelated.

Untimely Filed Notice of Appeal and Consequent Lack of Jurisdiction

HHS argues that pursuant to Rule 38, SCALCR, the Court should dismiss Appellant's appeal because her Notice of Appeal was filed with the ALC more than thirty days after receipt of the hearing officer's Order, in violation of Rule 33, SCALCR. HHS also argues that as a

result of failure to comply with Rule 33, SCALCR, the Court lacks jurisdiction to hear the case and thus Appellant's appeal should be dismissed pursuant to Rule 12(b)(1), SCRCR. I disagree.

According to Rule 68, SCALCR, "[t]he South Carolina Rules of Civil Procedure and the South Carolina Appellate Court Rules, in contested cases and appeals respectively, may, in the discretion of the presiding administrative law judge, be applied to resolve questions not addressed by these rules" (Emphasis added). The ALC rules do not address the question of whether a transfer to this Court of an appeal filed improperly in another court divests this Court of appellate jurisdiction that it otherwise would have possessed over the appeal. However, the South Carolina Supreme Court, in *In re November 4, 2008 Bluffton Town Council Election*, 385 S.C. 632, 686 S.E.2d 683 (2009), a case analogous to the present case, applied Rule 204(a), SCACR, to transfer an appeal that was timely filed, albeit in the wrong jurisdiction (the South Carolina Election Commission), to the proper jurisdiction – the court of common pleas sitting in its appellate capacity. Rule 204(a), SCACR states that "[i]n the event that the notice of appeal is filed in the wrong appellate court, the appellate court in which the matter is filed shall issue an order transferring the case to the appropriate appellate court." The Supreme Court not only applied Rule 204(a), SCACR to allow the transfer of an appeal originally filed with a non-court (let alone an appellate court), but it also allowed the transfer of the appeal to a court that was not inherently appellate, even though it was the appropriate appellate forum in that case. The Court's reasoning was "guided by the principle that courts should not interpret procedural rules to create a trap for unwary lawyers" and that "transferring th[e] case to the circuit court w[ould] serve the ends of justice by ensuring that the [matter would be] heard in the proper appellate forum." 385 S.C. at 641, 686 S.E.2d at 688 (internal citation omitted).

The present case, like *Bluffton Town Council Election*, involves an appeal that was timely filed in the wrong jurisdiction but was transferred to a court that was the appropriate appellate forum. Unlike in *Bluffton Town Council Election*, there is no ambiguity created by conflicting statutes that gives rise to an injustice. Nevertheless, I find that the facts of this case, as in *Bluffton Town Council Election*, require the appeal to be continued in this Court so that the ends of justice may be served. Appellant did timely file her appeal and provide notice thereof to HHS, so it was not prejudiced. Therefore, pursuant to Rule 68, SCALCR, and in accordance with Supreme Court's ruling in *Bluffton Town Council Election*, this Court elects to invoke Rule 204(a), SCACR, finding that the filing of Appellant's Notice of Appeal was timely and that this

Court thus has jurisdiction to hear this matter. Therefore, the Court denies HHS' Motion to Dismiss pursuant to Rules 33 and 38, SCALCR and Rule 12(b)(1), SCRCP.

Same or Substantially the Same Claims as Those Arising in a Pending Proceeding Between the Same Parties

HHS argues that because Appellant makes "frequent and substantial reference to an ongoing proceeding between the parties that began in 2007[,]" Appellant's case should be dismissed pursuant to Rule 12(b)(8), SCRCP. In the alternative, HHS argues that should the Court find that the claim involving the oximeter cable is a new claim, that the Court should grant its Motion in part by dismissing with regards to all of the other claims that Appellant raises. Though I find that the oximeter cable is a new claim that has not been raised in other, pending proceedings, I disagree as to dismissal of the remaining claims, because the remaining claims are not before the Court.

A motion to dismiss pursuant to Rule 12(b)(8), SCRCP requires "another action [that] is pending between the same parties for the same claim." This rule inherently requires claims to be raised in the present action. HHS is quite correct that Appellant makes a number of arguments and cites to many exhibits pertaining to a separate, ongoing proceeding, *B.W. v. S.C. Dep't of Health and Human Servs.*, docket no. 09-ALJ-08-0344-AP (ALC 2009), which was remanded to HHS by the ALC, specifically by the Hon. John D. McLeod, on July 30, 2012 and is still pending in the HHS Division of Appeals and Hearings. In her Response to Motion to Dismiss, Appellant even contends that "this appeal is part and parcel of the appeal Appellant filed in 2007[,]" which was the case that Judge McLeod originally remanded for more information and later came back up before him in 2009. Thus, even had these issues been properly raised in this case, the Court would have found that dismissal was warranted pursuant to a Rule 12(b)(8) theory.

At any rate, Appellant tried to incorporate by reference exhibits from the other proceeding into the Record on Appeal in this case through her Initial Brief, just as she tried to incorporate by reference in her response to the hearing officer's Prehearing Conference Order allegations from her 2007 complaint.⁷ However, the ALC Rules do not allow for the inclusion of

⁷ Appellant also requested in a January 31, 2013 email sent to Beth Hutto, Byron Roberts, Rick Hepfer, and the email addressee, kanthony@anthonylaw.com, that the record in the prior, pending appeal be supplemented with the denial of Appellant's prior authorization request for an oximeter cable. She intended this denial "to provid[e] . . . additional evidence that DHHS has improperly reduced and denied services in violation of the ADA and the

exhibits within appellate briefs. Appellant should have filed a Motion to Supplement the Record on Appeal, which can contain exhibits pursuant to Rule 36, SCALCR. Because Appellant failed to file a Motion to Supplement the Record on Appeal, the Court can only rely on what is based therein and will only entertain arguments that are based thereon. *See* Rule 36, SCALCR (“The Administrative Law Judge will not consider any fact which does not appear in the Record.”). Consequently, the only issue before this Court pertains to the hearing officer’s dismissal of Appellant’s case concerning HHS’ denial of a prior authorization request for an oximeter cable. Any other issues arising from other pending appeals or litigation, though perhaps referenced in the Record on Appeal, are not at issue in this case and will not be considered by this Court.⁸

Medicaid Act.” It thus appears that Appellant’s original intent was to supplement the record in the prior, pending litigation with documents and the issue from the present appeal, which, in this same email, she said she would be filing. However, these two appeals are not one and the same, despite Appellant’s attempt to make them so.

⁸ Appellant raised concerns about HHS’ perceived lack of progress in carrying out Judge McLeod’s July 30, 2012 Order. But attempting to have this Court address the issues in that case through the backdoor of a Brief in this case is inappropriate. Instead, if Appellant believes she is aggrieved by HHS’s actions, or lack thereof, in that case, that matter must be properly brought before this Court.

Furthermore, Appellant raised several contentions regarding this Court’s procedures in her Amended Reply Brief, specifically on pages 9-10. Appellant contends that the case continues Respondent’s “ongoing and unconstitutional pattern of violating the Separation of Powers provision of the Constitution of South Carolina . . . by cycling and recycling of ‘fair hearing’ cases between DHHS and the [ALC].” She also contends that the ALC is violating federal law by not allowing the case to reach a final decision within 90 days. Appellant adds that “the wait time for Medicaid appellants is much longer in the Administrative Law Court, because each time the case is remanded and either heard or dismissed by the DHHS hearing officer, this Court treats the case as a new one, beginning at day one.”

Appellant’s contentions are based upon a gross misunderstanding of this Court’s review of these cases. S.C. Code Ann. § 1-23-600 (E) (Supp. 2012) sets forth that review in these cases does not occur until a final decision in a contested case is made. Moreover, the cases before the Court follow a set time for submission of the record and briefs unless the Court expands or shortens that schedule. *See* Rules 36 (A) and 37 (A), SCALCR. In fact, Appellant’s arguments fail to recognize Appellant’s own contributions to a delay in the conclusion of these proceedings. The reason for one of the delays and “recycling” of cases back to HHS is that counsel for Appellant in Judge McLeod’s case in 2009, docket no. 07-ALJ-08-0626, who is also counsel for Appellant in the instant case, failed to produce a “Memorandum of Understanding” as requested by the hearing officer. Indeed, that remand order was completely concerned with directing Appellant to provide detailed information to Respondent, the hearing officer, and the Court regarding her various allegations. Other delays occurred when counsel for Appellant sent a response to the hearing officer’s Prehearing Conference Order to the wrong person, resulting in a submission-date extension, and thus a delay, of two weeks, and when counsel filed the Notice of Appeal with the wrong court, resulting in a delay of just over a month, even though counsel has practiced for many years in the correct court and could have instructed her runner where specifically within the building to file it. Other delays were due to four deaths in counsel’s and her spouse’s families in less than two months, as well as counsel having had two other hearings in other courts and the retirement of counsel’s longtime secretary, all occurring just prior to deadlines. Incidentally, the Court received no complaints when it granted Appellant’s counsel the extensions of time that she requested.

Arbitrary or Capricious

Turning now to the hearing officer's dismissal of Appellant's appeal of HHS's denial of Appellant's prior-authorization request for an oximeter cable, the issue is whether the hearing officer's decision was arbitrary or capricious pursuant to S.C. Code Ann. § 1-23-380(5)(f).

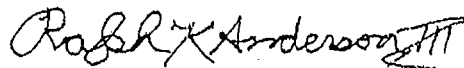
"A decision is arbitrary if it is without a rational basis, is based alone on one's will and not upon any course of reasoning and exercise of judgment, is made at pleasure, without adequate determining principles, or is governed by no fixed rules or standards." *Trimmier*, 405 S.C. at ---, 746 S.E.2d at 495.

In this case, however, Appellant failed to raise as an issue on appeal the hearing officer's dismissal of Appellant's appeal for abandonment due to failure to submit a statement of intent to continue her appeal and attend a Fair Hearing. It is only in her Reply Brief that Appellant makes an argument specifically addressing the hearing officer's decision in this matter to dismiss Appellant's appeal for abandonment. But "[i]t is axiomatic that an issue cannot be raised for the first time in a reply brief." *McClurg v. Deaton*, 395 S.C. 85, 87 n.2, 716 S.E.2d 887, 888 n.2 (2011). "[A]n argument made in a reply brief cannot present an issue to the appellate court if it was not addressed in the initial brief." *Simmons v. SC STRONG*, 402 S.C. 166, 173 n.2, 739 S.E.2d 631, 635 n.2 (Ct. App. 2013) (citing *Glasscock, Inc. v. U.S. Fid. & Guar. Co.*, 348 S.C. 76, 81, 557 S.E.2d 689, 692 (Ct. App. 2001)). Because Appellant failed to challenge the hearing officer's decision in her Initial Brief, that decision is the law of the case.

ORDER

IT IS THEREFORE ORDERED that the hearing officer's decision to dismiss Appellant's appeal is **AFFIRMED**.

AND IT IS SO ORDERED.



Ralph K. Anderson, III
Chief Administrative Law Judge

October 11, 2013
Columbia, South Carolina

ORDER OF DISMISSAL IN THE APPEAL MATTER OF
B. W. (PETITIONER) v. SCDHHS (RESPONDENT)

Appeals' Case # 13-MISC-021 (DME)

Medicaid # 6780499394

Hearing Date: Not held

JURISDICTION

Procedure in this case is governed under the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services (SCDHHS) 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 (Reg. 126-150, et seq.) and the South Carolina Administrative Procedures Act (S.C. Code Ann. 1-23-310, et seq.).

PROCEDURAL HISTORY

The Petitioner is Medicaid eligible. Apria, a provider of durable medical equipment (DME) submitted, on behalf of the Petitioner, a prior authorization request for a piece of medical equipment, specifically an oximeter cable. Kepro, an agent of the Respondent, South Carolina Department of Health and Human Services (SCDHHS) denied the request because no supporting clinical information was submitted with the request. On January 31, 2013, the Petitioner's attorney's appeal was received in the Division of Appeals and Hearings.

ISSUE

The issue is whether the Respondent, through its agent, correctly denied prior authorization for durable medical equipment for the above referenced Medicaid beneficiary. Any issues raised in the proceedings or hearing of this case but not addressed in this Decision are deemed denied.

FINDINGS OF FACT

Having studied the exhibits and closely passed upon their credibility, I make the following Findings of Fact by a preponderance of the evidence:

1. On February 5, 2013, this Hearing Officer issued a Pre Hearing Conference Order to the Petitioner's attorney and the Respondent directing the two parties to participate in a pre-hearing conference. The Petitioner was ordered to provide this Hearing Officer with a statement of her intention to continue with the appeal on or before March 19, 2013, otherwise, this matter would be dismissed.
2. On February 6, 2013, the certified copy of this Pre Hearing Conference Order was delivered to the Petitioner's address.

3. On March 19, 2013, correspondence from the Petitioner's attorney was received via facsimile. However, this correspondence did not address the issues of this appeal and did not state the intention of continuing with this appeal.
4. On March 27, 2013, this Hearing Officer sent an email to the Petitioner's attorney offering an extension until April 2, 2013 to submit the statement of intention.
5. As of the undersigned date, the Petitioner's attorney has not returned a response to this Hearing Officer's Pre Hearing Conference Order.

APPLICABLE LAW

"A Hearing Officer has the authority, among other things, to: direct all procedures, issue interlocutory orders; schedule hearings and conferences; preside at formal proceedings; rule on procedural and evidentiary issues; require the submission of briefs and/or conclusions of law; call witnesses; recess, continue, and conclude any proceedings; dismiss any appeal for failure to comply with the requirements of this subarticle." South Carolina Department of Health and Human Services, Chapter 126, "Administration" R.126-154, §44-6-90, S.C. Code, 1976, as amended.

CONCLUSIONS OF LAW

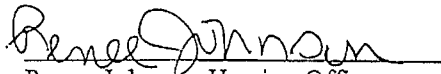
Based upon the above Findings of Fact and Applicable Law, I conclude the following as a matter of law:

In accordance with SCDHHS regulation 126-154, the Petitioner has abandoned the appeal request and this matter is dismissed.

DECISION

This matter is hereby **DISMISSED**.

AND IT IS SO ORDERED.


Renee Johnson, Hearing Officer
Division of Appeals & Hearings

DATED AT COLUMBIA,
South Carolina

April 4, 2013

Rec'd Nov 20, 2013
PCH

Nikki Haley GOVERNOR
Anthony Keck DIRECTOR
P.O. Box 8206 • Columbia, SC 29202
www.scdhhs.gov

November 19, 2013

CERTIFIED MAIL

Patricia Harrison, Esquire
611 Holly Street
Columbia SC 29205

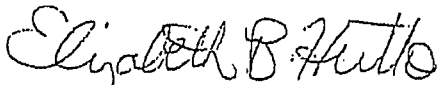
RE: Administrative Decision in the Appeal Matter of Brook Waddle v. SCDHHS
Appeals' Case # 07-MISC-028
Medicaid # 6780499394

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

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

RN to come out for two hours per day, participants who have RN hours usually have the RN come out for at least half a day.

Dr. Veldheer discussed the difficulties families face in finding RN care. It appears as though the Respondent requires the families and the participants to secure the type of care and hours needed rather than requiring the Service Coordinator to provide that assistance. Dr. Veldheer noted that, frequently, the family or the participant must seek out a number of nursing agencies to find one that will meet their needs. Dr. Veldheer testified that, as the nursing agencies are private companies, they can choose to accept a case or not and, as private companies, they may or may not have the appropriate staff for every case. T. at 221. "...for these families, it's a constant process to get the kind of staffing you need in your authorized hours." T. at 237. Dr. Veldheer did not know how "diligent" the Petitioner's family had been in seeking RN care for her. T. at 237.

In spite of the history of this appeal with RN hours as a central issue, Dr. Veldheer believes that the Petitioner has not requested RN services. T. at 237. However, Dr. Veldheer feels that an RN should see the Petitioner "at least every week, either for a few hours or for a day." T. at 220-221. Apparently, due to her misunderstanding of the Petitioner's request for care, Dr. Veldheer had not previously suggested that the Petitioner receive RN services even though she was aware that the Petitioner needed such care.

In accordance with the Service Plan, the RN hours were to be evaluated after 30 days, but continue in some amount per week. The record shows no evidence of an evaluation of the Petitioner after her first 30 days home from the hospital. Dr. Veldheer did not know whether there was an evaluation by a doctor after the first 30 days nor did she know whether the

Petitioner has ever had an evaluation by a doctor that finds that Petitioner does not need 14 hours per week of RN care. T. at 67.

The Petitioner has never received ongoing RN care at home. The service provider sends an RN to the home periodically to supervise the LPN by checking her paperwork. T. at 205. The RN's review of the LPN's care is not part of the Petitioner's service plan or a requirement of the Respondent. Dr. Veldheer is aware of this supervisory arrangement but seems to feel the management of the quality of care provided to the Petitioner is the responsibility of the contracted service provider. Dr. Veldheer testified that she does not know how often the supervising RN comes to Petitioner's home and that SCDDSN does not have standards for that supervision. T. at 233. "We don't have standards because we don't provide nursing services. The provider is the nursing agency and they have standards" T. at 234

Since Jan 2010, the Waiver stated that the combination of nursing and attendant cannot exceed 70 hours per week. The hours can be used flexibly throughout the week. Prior to that time, there was a 12 hour per day limit. T. at 218. The mix of attendant and nursing care is according to what the recipient requests and what gets approved by the centralized nursing review. Dr. Veldheer pointed out that, under current limits, the Petitioner could receive 56 hours per week of LPN. That would give the Petitioner's mother 8 hours per day to leave the home, sleep, etc. T. at 220-221. However, Dr. Veldheer does not know whether the Petitioner is aware of that option. Dr. Veldheer knows that the Petitioner has been told that the maximum LPN nursing hours she could get was 34. Dr. Veldheer explained that B.W. was told that 34 LPN hours were the maximum she could receive because she was receiving 36 hours of attendant care at the time. T. at 230. Dr. Veldheer did not seem to feel that she should have clarified for the

Petitioner that there was not a 34 hour LPN limit but that nursing hours and could be combined in a suitable way for the Waiver participant within the limit.

The Service Coordinator has the authority to determine the hours of attendant care.

78. Petitioner's Service Coordinator felt her opinion as to whether the Petitioner required 24 hours per day of care was "not relevant." Also, the Service Coordinator believes her opinion as to whether the Petitioner can be left alone is "not relevant." T. at 89.

During the 2009 hearing, the Petitioner's treating physician, Dr. Gabel, testified via affidavit stating that she agreed with Dr. Silvestri's assessment that the Petitioner required 28 hours per week of RN services "to provide observation, intervention and to prevent regression and identify medical problems which, if left untreated, would require readmission to the hospital." Dr. Gabel opined that the Petitioner requires 84 hours per week of LPN services to maintain maximum functional status and to prevent institutionalization. She also stated that the Petitioner requires attendant care at all times when an RN or LPN are not present, to assure her safety. Record of 2009 Matter at 905-906. Dr. Gabel's testimony was not subject to cross examination.

The Petitioner's LPN, Ms. Galus, was one of only two witnesses at the 2012 hearing who had ever met the Petitioner and was the only witness with medical training at either the 2012 or the 2009 hearings with direct knowledge of the Petitioner's medical needs. Ms. Galus testified to the complicated and fragile medical state of the Petitioner. She also testified to the types of care that the Petitioner requires. The Petitioner needs to be suctioned throughout the day. A mucus plug in her tracheostomy tube could be deadly without a nurse or the Petitioner's mother there to suction. T. at 174. The Petitioner's trach must be cleaned frequently. Only a nurse or

the Petitioner's mother can clean the trach. T. at 179. The nurse also provides the Petitioner's bowel program and bathes her. T. at 191.

The Petitioner cannot be left alone. The Petitioner's mother must be present while an attendant or respite care provider is in the home as these service providers cannot suction the Petitioner. Therefore, the Petitioner's mother can only leave the home when a nurse is present. T. at 175. The Petitioner also requires a catheter. Only a nurse or the Petitioner's mother can reinsert the catheter if it comes out. T. at 174. Only the nurse or the Petitioner's mother can keep her safe when she suffers from a grand mal seizure. The attendant is not trained to handle seizures. T. at 198. The attendant can only sit with the Petitioner and feed her. The attendant is not qualified to provide any other care. T. at 200.

Ms. Galus described the Petitioner's frequent bouts with pneumonia which require suctioning as much as 3-5 times per hour. The Petitioner has also suffered from frequent urinary tract infections. The Petitioner has a history of decubitus ulcers and must be repositioned at least once or twice every two hours. The Petitioner has contractures and her arms cannot be straightened. If her arms are stretched, her skin will break. P.T. and O.T. would improve the contractures. However, the Petitioner is not currently receiving P.T. and O.T. services because her mother is too exhausted to take the Petitioner to therapy. T. at 177-180.

The Petitioner takes daily medications for seizures, depression, to assist with bowel movements, a stool softener, neuropathy pain, prevention of muscle spasms, prevention of bladder spasms, and for migraine headaches. The Petitioner has painful kidney stones. T. at 192-197. Since developing kidney stones, the Petitioner has had problems with her catheter leaking. Because the Petitioner cannot feel if she is wet, she is at risk of being wet for extended periods when her catheter leaks. This causes her skin to break down. T. at 194.

Ms. Galus testified that if the RN hours were 6-8 per day, the Petitioner would be able to find an RN in her area that would be willing to provide the care. T. at 200. Ms. Galus testified to the Petitioner's need for RN care due to the Petitioner's numerous medications (some administered by IV), frequent bouts of pneumonia, frequent urinary tract infections, decubitus ulcers and other skin breakdowns, and infection risks. Ms. Galus described the services an RN could provide that an LPN cannot. RNs can provide all treatment with IVs while LPNs have limited ability to work with IVs. RNs can perform lung assessments and determine when oxygen should be administered. RNs can also draw blood and monitor blood levels. T. at 205-208.

Dr. Veldheer and Ms. Wingo, the Petitioner's Service Coordinator, described the process whereby the Respondent determines the number of nursing hours that are needed by Waiver participants. Dr. Veldheer testified that after the 2010 cuts, HASCI Waiver began a centralized nurse review to make certain that participants who needed nursing services had the appropriate amount of nursing. Prior to that time, there was no nursing review at the agency to see if participants were getting the services they needed. T. at 226-227. Ms. Wingo also described the process for the annual review of nursing hours. The Service Coordinator has a form provided by SCDDSN that must be signed annually by a physician and sent to the SCDDSN centralized nurse who determines how many nursing hours are needed. According to Ms. Wingo, the SCDDSN centralized nurse is, "...the one who decided if these are appropriate or not." T. at 89. When asked about her opinion regarding whether the Petitioner needs additional services, Ms. Wingo responded that her opinion is "not relevant." T. at 91. The SCDDSN nurse who determines the Petitioner's needs has never met the Petitioner nor been to her home. The centralized nurse completes an annual record review to determine the number of nursing hours that participants

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.

Three medical record reviews conducted by the SCDDSN centralized nurse were entered into the record as Petitioner's Exhibit 28. The August 9, 2011 medical record review noted the numerous medical conditions and complications that afflict the Petitioner:

"Spastic quadriplegia - her Baclofen pump has since been removed, she now received Baclofen by mouth - she experienced an abdominal hematoma secondary to Baclofen pump removal - she had acute blood loss secondary to the hematoma.

Suprapubic catheter - neurogenic bladder - peri/catheter care - monitor for signs and symptoms of UTI

Bowel program - implemented by the nurse - history of constipation

History of pulmonary embolus in 2007 - required daily anticoagulant medications - an AV fistula was placed during a recent hospitalization in 2011 for INR checks which will need chronic checks for coagulation until measures are sufficient per Physician [perimeters]

History of experiencing 4 seizures since January 2011 that required hospitalizations and she was diagnosed with urinary tract infections which the doctors believe contributed to the seizure activity - seizure precautions/monitor for seizure activity

Since January 2011, she has required 3 or 4 hospitalizations due to chronic urinary tract infections

She experienced hypotension during her hospitalization in February, 2011, but her blood pressure has since returned to normal range - monitor vital signs

In April 2011, she was hospitalized for confusion and altered mental status which she was diagnosed with urinary tract infection

History of episodes of depression/anxiety

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 (11th 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. L.C.*, 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
TOTAL						\$ 140,148.60

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

Nikki Haley GOVERNOR
Anthony Keck DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
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

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,	)	
	)	ORDER
-v-	)	RESPONDENT'S MOTION FOR
	)	RECONSIDERATION
	)	
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.¹ 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."

¹ 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

Elizabeth B. Hutto
Hearing Officer

DATED AT COLUMBIA,
South Carolina

December 23, 2013

IN THE ADMINISTRATIVE LAW COURT

Appeal of the Decision of DHHS Hearing Officer Renee Johnson

Brook Waddle,
Appellant,

v.

South Carolina Department of Health and Human Services,
Respondent

NOTICE OF APPEAL

1. Name, address and telephone number of person requesting appeal:

Brook Waddle
142 Royal Burgess Drive
Landrum, South Carolina 29322
864 590 5578

2. Attorney for Appellant:

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

3. Attorney for Respondent:

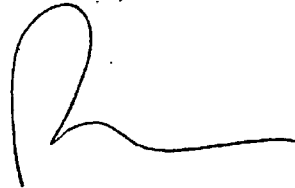
Richard Hepfer
South Carolina Department of Health and Human Services
PO Box 8206
Columbia, South Carolina 29202-8206

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MAY 09 2013

SC Court of Appeals

3. **General statement of grounds for appeal:** The hearing officer dismissed this appeal which is related to wrongful acts by DHHS occurring after the hearing which was held on October 30 and 31, 2012. Waddle's appeal was dismissed without providing a fair hearing in violation of Waddle's due process rights guaranteed by the United States Constitution, the Constitution of the State of South Carolina, 42 U.S.C. 1396a(a)(3) and the "fair hearing" regulations contained at 42 C.F.R. 431.200 et. seq. These violations of federal regulations include, but are not limited to the provision of defective notices, violation of the procedural rights of Waddle contained at 42 C.F.R. 431.242 and the requirement contained in 42 C.F.R. 431.244 that the agency base its decision "exclusively on evidence introduced at the hearing." Respondent has violated the reasonable promptness requirements of 42 U.S.C. 1396a(a)(8) by failing to comply with this Court's order of July 30, 2012 and by failing to provide needed services and equipment and a final decision within 90 days.
4. **Final decision of the DHHS hearing officer is attached.** Also enclosed is Appellant's Response to the hearing officer's order.
5. **A transcript is not necessary, because Waddle's 2013 appeal was dismissed without providing a hearing on the merits, in violation of the applicable statute and regulations.**



Patricia L. Harrison, Attorney for Appellant
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Columbia, South Carolina 20205
May 9, 2013

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM THE SOUTH CAROLINA ADMINISTRATIVE LAW COURT

Honorable Ralph King Anderson, Jr.

Docket No.: 13-ALJ-08-0267-AP

Brook Waddle,
Appellant,

v.

South Carolina Department of Health and Human Services,
Respondent.

NOTICE OF APPEAL

Brook Waddle appeals the order of Honorable Ralph King Anderson, Jr. dated and filed October 11, 2013 in Richland County, South Carolina, which was received by Appellant on October 15, 2013.



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Other Counsel of Record:
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November 11, 2013

RECEIVED - ALJ-08-0267-AP

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BY:

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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APPEAL FROM SOUTH CAROLINA
Administrative Law Court

NOV 24 2014

SC Court of Appeals

Ralph King Anderson III, Administrative Law Judge
Trial Court Case No.: 2013-ALJ-080267-AP

Appellate Case No.: 2013-002415

Brook Waddle,.....Appellant,

v.

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

RESPONDENT'S MOTION TO DISMISS APPEAL

SOUTH CAROLINA DEPARTMENT
OF HEALTH AND HUMAN SERVICES

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Counsel for the Respondent

FACTS

Respondent ("DHHS") hereby submits its Motion to Dismiss pursuant to Rule 240 of the South Carolina Appellate Court Rules and shows this Honorable Court the following:

Appellant ("Waddle") was injured in an automobile accident in 2005, which rendered her quadriplegic. Following the accident, Waddle became a Medicaid-eligible individual, who has been receiving services under the South Carolina Head and Spinal Cord Injury ("HASCI") waiver program. Under the waiver program, participants can receive a mix of services through the South Carolina Department of Disabilities and Special Needs ("DDSN"). Waivers are mechanisms within the Medicaid program under which, by having certain generic requirements of the Medicaid program "waived," States are able to provide services to eligible participants in ways not allowed under the regular Medicaid program. This waiver and other waiver programs operated by DDSN are for home and community based services under Section 1915(c) of the Social Security Act. 42 U.S.C. § 1396n(c). These types of waivers allow services to be provided in the home or community in lieu of institutional services. DDSN is responsible for the day-to-day operations of the waiver program, but DHHS is the single agency responsible for the South Carolina Medicaid program. [Order on Appeal, pp. 1-2].

Apria Healthcare, Inc. ("Apria"), is a provider of durable medical equipment ("DME"). Apria submitted to KePro, an agent of DHHS, a prior authorization request on behalf of Waddle for a piece of DME, specifically requesting an oximeter cable which measure that oxygen saturation of the blood. However, the request was denied

because Apria did not provide any supporting clinical information with the request. Both Waddle and DHHS attempted to resolve the issue without success. [Id., p. 2].

On January 31, 2013, Waddle filed an appeal of the denial of the oximeter cable to DHHS's Division of Appeals and Hearings. On April 4, 2013, the agency hearing officer issued an Order dismissing Waddle's appeal on procedural grounds. [Id., p. 3]. Waddle appealed the Order dismissing the appeal to the Administrative Law Court ("ALC"), which affirmed the procedural dismissal in an Order dated October 11, 2013, which is the subject of this appeal. The ALC noted in the Order that, as of March 19, 2013, "there is nothing in the Record on Appeal to indicate that the issue has since been resolved." [Id., p. 2 at footnote 4].

ANALYSIS

Generally an appellate court "will not pass on moot and academic questions or make an adjudication where there remains no actual controversy." Sloan v. Dep't of Transp., 379 S.C. 160, 167, 666 S.E.2d 236, 240 (2008) (internal citations omitted).

As evidenced by the Affidavit attached hereto as Exhibit 1, if the proper code to request an oximeter cable is used by the ordering healthcare provider, the equipment should be approved without the necessity of prior authorization. [Exhibit 1]. In the present case, the healthcare provider, Apria, incorrectly coded the request for the oximeter cable and, therefore, the request was denied. However, the coding issue was discovered when the denial was appealed and the cable was approved manually and Waddle received the cable. Moreover, if the correct code is used by the provider in the future, barring any other error, it will be approved without prior authorization. [Id.].

Based upon the fact that the coding error was identified and the DME provided to Waddle, the issue on appeal is moot. Even if Waddle prevailed in her appeal to this Court, the relief would be to remand the matter to DHHS's Division of Appeals and Hearings for a fair hearing to determine whether or not the denial of the oximeter cable was proper, and whether or not the DME should be provided to Waddle. As DHHS has resolved the issue and provided the oximeter cable to Waddle, and DHHS has indicated that absent any future coding error the oximeter cable will continue to be provided without prior authorization, there is no need for a fair hearing or relief that the fair hearing officer could provide. As such, the present appeal should be dismissed as moot as there remains no actual controversy.

CONCLUSION

For the reasons set forth herein, DHHS respectfully requests that the Court dismiss with appeal as moot.


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Counsel for the Respondent

Columbia, South Carolina
November 24, 2014

STATE OF SOUTH CAROLINA)
)
COUNTY OF RICHLAND) AFFIDAVIT

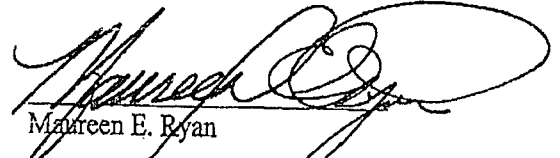
Personally appeared before me Maureen E. Ryan, who being duly sworn deposes and says as follows:

1. That she is a Program Coordinator II in the Division of Health Services of the South Carolina Department of Health and Human Services (SCDHHS);
2. That, in her position she drafts and publishes the policy which sets forth the method by which requests for oximeter cables and other durable medical equipment (DME) are processed, including for participants of the Medicaid Waiver Programs managed by the Department of Disabilities and Special Needs (DDSN) for the SCDHHS;
3. That, once the need for such a cable by an adult Waiver participant is identified, arrangements should be made for the participant to see a Medicaid-enrolled DME provider in order that a request for the product or accessory may be certified as medically necessary and submitted by the provider to the Medicaid agency;
4. That, all such requests, along with the initial certification of medical necessity are sent by the provider to the SCDHHS Office of Claims, Operations and Provider Relations, where they are again reviewed and, if proper, are approved to be supplied by the provider;
5. That, although the individual is in a Waiver administered by the DDSN, the equipment would be requested, processed, and paid through the regular Medicaid Program;
6. That, the proper code by which to request an oximeter cable is A4606, and if this code is used by the ordering healthcare provider, this code should be approved without the necessity of a prior authorization;
7. Upon researching this issue, it appears that previously, for this Participant, B.W., Medicaid ID # 6780499394, an oximeter cable was incorrectly coded and denied,

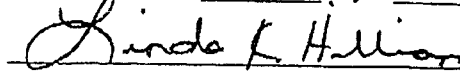


however, upon appeal the miscoding by the provider was discovered and the cable was manually approved, and the Participant received the cable;

8. If the correct code is used by the provider to bill for this equipment, barring any other error, it will be approved without prior authorization.


Maureen E. Ryan

Sworn to me this 6th day of Nov., 2014



Notary Public for South Carolina

My Commission Expires 6/3/15

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

B.W.,	)	
	)	
Appellant,	)	
	)	
v.	)	MOTIONS TO DISMISS OR,
	)	IN THE ALTERNATIVE,
South Carolina Department of Health and	)	PARTIAL MOTIONS TO
Human Services,	)	DISMISS
	)	
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

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), SCRPC, and Rule 33, SCALCR

A motion to dismiss filed under Rule 12(b)(1), SCRPC, 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), SCRCPP.

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

A motion to dismiss pursuant to Rule 12(b)(8), SCRCPP, 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,



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Columbia, South Carolina
September 11, 2013

THE STATE OF SOUTH CAROLINA
Administrative Law Court

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Docket No.13 ALJ 08-0267-AP

Brook Waddle Appellant,

v.

South Carolina Department of Health and Human Services Respondent.

APPELLANT'S RESPONSE TO MOTION TO DISMISS

Patricia L. Harrison
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803-256-2017

ATTORNEY FOR APPELLANT

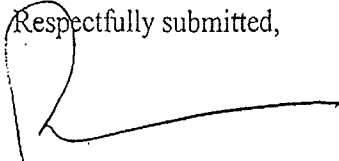
For the reasons set forth in Appellant's Reply Brief, the Respondent's Motion to Dismiss should be denied. The cited Rules established by the South Carolina Supreme Court require that a court may not dismiss an appeal because it is filed in the wrong court. SCRAP Rule 204. The receiving court must transfer the case to the correct court under those rules. The filing of the Notice of Appeal at the desk in the building of the South Carolina Administrative Law Court was excusable and Respondent would not be prejudiced by this Court's compliance with Rule 204.

Respondent argues that this appeal is part and parcel of the appeal Appellant filed in 2007. It is uncontradicted that more than 90 days has expired since Waddle requested a final decision in that case and Respondent failed to include in the Record on Appeal the records Appellant incorporated in her response to the hearing officer's pre-hearing order.

For these reasons, the Respondent's Motion to Dismiss should be denied.

Appellant's counsel had two deaths in her family since Respondent filed its Motion to Dismiss requiring out-of-town travel (her own aunt in Rutherfordton, North Carolina and the aunt of her husband in McCormick/Greenwood, South Carolina) and two hearings last week (in the Probate Court and the Family Court). Appellant requests that she be allowed to supplement this Response by filing a Supplemental Response to Respondent's Motion to Dismiss due to the short time provided by the Rules to respond to a Motion to Dismiss.

Respectfully submitted,



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September 23, 2013

THE STATE OF SOUTH CAROLINA
Administrative Law Court

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Docket No. 13-ALJ-08-0267-AP

Brook Waddle

Appellant

South Carolina Department of Health and Human Services

Respondent

APPELLANT'S INITIAL BRIEF

Patricia L. Harrison
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803-256-2017

ATTORNEY FOR APPELLANT

Statement of Issues on Appeal.

1. The issues raised in this appeal are encompassed in the complaint Appellant filed with DHHS on April 28, 2007 which included the issue of the failure of DHHS to provide services Brook needs to remain in her home, including but not limited to assistive technology and other services.
2. DHHS and this Court, as agencies of the executive branch of state government, have violated the separation of powers provision of the South Carolina Constitution, Brook's Constitutional right to due process, her statutory right to notices of the denial, reduction or termination of Medicaid services meeting the requirements of 42 C.F.R. 431.210, her right to an evidentiary hearing meeting the requirements of 42 C.F.R. 431.242 and 244 and her right to a final administrative decision within 90 days of her April 28, 2007 appeal by failing to rule upon all of the issues raised in her 2007 appeal and delaying her opportunity for judicial review for more than six years.
3. DHHS has violated its duty to assure that Brook's health and welfare are protected and it cannot deny critical services based on its provider, Apria, failing to provide its middleman, Kepro, with "supporting clinical evidence" when DHHS has extensive clinical records to support her need for an oximeter cable.
4. DHHS has violated the reasonable promptness requirement of the Medicaid Act by failing to provide medically necessary services with reasonable promptness, in the amount, duration and scope necessary to prevent institutionalization and hospitalization, giving the greatest deference to the opinion of her treating physicians.
5. DHHS has violated the Americans with Disabilities Act by denying, reducing and terminating services, because Brook's needs may be met in the least restrictive setting at home through reasonable accommodations which would not cause a fundamental alteration in the State's system.

Standard of Review.

This tribunal may reverse or modify the agency's decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions or decisions are: (a) in violation of constitutional or statutory provisions; (b) in excess of the statutory authority of the agency; (c) made upon unlawful procedure; (d) affected by other error of law; (e) clearly erroneous in view of the reliable, probative and substantial evidence on the

whole record; or (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

Statement of the Case.

This action was initially commenced on April 28, 2007, but more than six years later, Brook has not received a final, appealable order on her administrative appeal. The most recent violation of the Medicaid Act by DHHS, which led to the filing of this “appeal” to prevent the reduction in life-saving supplies/equipment, resulted from DHHS denying payment for an oximeter cable which is required to measure Brook’s oxygen level to determine whether oxygen needs to be administered. R. at 9. See also Declaration of Rhonda Galus, LPN at Exhibit 2 and Declaration of Kathy Hoover, RN at Exhibit 3, which are attached, because DHHS failed to provide a hearing at which Appellant could present evidence. Brook objected to the denial of payment for supplies necessary for treatment of her tracheotomy on January 30, 2013. DHHS denied payment for this equipment because it claims that the provider, Apria, did not provide its middleman, KePro, with “supporting clinical information” along with its request for reimbursement. R. at 14. Because Brook has not been provided with funding for a speech device, she was unable to communicate with Apria or KePro. Exhibit 2.

The is Brook’s third request for a “fair hearing.” (Brook maintains throughout this Brief that this denial of funding for the oximeter is part of a pattern of denials of needed services described in her 2007 appeal.) Appellant refers in this Brief to evidence which has been presented to DHHS and this Court during the past six years of this appeal. Included as Exhibit 1 is the transcript of the hearing held on October 30 and 31, 2012. The reference to “Record” in

this brief refers to the Record on Appeal in Docket No. 07-ALJ-08-0626-AP, which is incorporated herein by reference, since the Office of Hearings and Appeals failed to transmit the entire Record to the Administrative Law Court and DHHS has treated Brook's complaint about the most recent denial as if it was a new appeal. Pages from the scant "Record" in this case, which was submitted to this Court by the DHHS Office of Hearings and Appeals on June 27, 2013, are referenced herein as "R." Brook also submits evidence presented to DHHS in October of 2012 and an affidavit of Brook's LPN, Rhonda Galus. These documents were not included in the Record on Appeal because the hearing officer dismissed her appeal without providing an evidentiary hearing and an opportunity, as required by 42 C.F.R. 431.242 to "Establish all pertinent facts and circumstances" and to present her argument without undue interference.

Brook's first request for a fair hearing was filed on February 6, 2007, when DHHS notified Brook that her Medicaid eligibility was being terminated. The reason for termination of these benefits was that DHHS determined that she no longer resided in South Carolina, having sent Brook to Mt. Sinai Medical Center in New York for surgery for three weeks. ("They said she was a resident of New York, so we had to retain you as a lawyer to try to help us get her back on Medicaid. Record at 154).

In March, 2007, DDSN sent a notice of denial of the services Brook's doctors ordered and she filed this appeal on April 28, 2007. Record at 838 and 1420. In Brook's second appeal, Brook claimed that Respondent violated various requirements of the Medicaid Act and she requested, pursuant to 42 C.F.R. 431.244 a hearing an final administrative determination within 90 days. That appeal included ongoing violations of the Medicaid Act resulting from DHHS failing to provide assistive technology and other services Brook requires to remain in her home.

In the appeal letter, Brook stated:

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.

Record at 1474. Brook requested an evidentiary hearing and a final decision within 90 days. *Id.* But, instead of providing Brook the requested evidentiary hearing, the hearing officer issued an “Order to Show Cause” on August 17, 2007, requiring Brook’s counsel to brief the issues in her appeal prior to offering an evidentiary hearing. Then, on November 16, 2007, finding other issues raised in the appeal were “moot” (because some nursing services were accepted by Brook), the hearing officer dismissed Brook’s appeal, finding that the “Memorandum of Understanding” was not provided as ordered.

Briefs were filed by both parties, on March 2, 2009, nearly two years after Brook first requested a fair hearing, and the South Carolina Administrative Law Court remanded her appeal to DHHS, requiring the agency to provide an evidentiary hearing. A hearing was held on April 24, 2009. The DHHS hearing officer issued an order on July 9, 2009 finding that “ten (10) hours per day of nursing was authorized” and that Brook was entitled to receive “any Medicaid reimbursable services that are medically necessary.” The order did not address issues raised by Brook related to personal care attendant services, the communications device or other issues, including assistive technology and other services that were raised in the appeal.

On January 1, 2010, DDSN and DHHS established caps on waiver services across the State. Without notifying Brook’s legal counsel, Brook’s Service Coordinator informed her that

appealing these reductions would be futile and that no exceptions to the caps were allowed.

(Testimony and evidence presented at fair hearing held on October 30 and 31, 2013.)

Unbeknownst to her attorney and despite Brook's pending appeal, Respondent further reduced Brook's LPN nursing and personal care attendant hours, below the amount the DHHS hearing officer had determined she required in 2009. Despite the fact that this appeal was based on Brook's request for additional hours, during the appeal, in violation of its own policies, DHHS reduced Brook's hours of nursing and personal care attendants from 98 hours a week to just 70 hours a week (PCA and nursing) pursuant to the January 1, 2010 amendments.¹ (Testimony and evidence presented at October 30 and 31, 2012 fair hearing contained in Exhibit 1.)

A hearing was held in the South Carolina Administrative Law Court on March 1, 2010, just two months after these additional reductions were put into place. (Brook was unable to attend due to health issues, which resulted in an eight day hospitalization.) But the Administrative Law Court did not issue an order until May 14, 2012. The Court withdrew this order after Brook's counsel filed a motion to reconsider on May 24, 2012. A third round of oral arguments was ordered by the Administrative Law Judge - but Respondent still did not advise Judge McLeod that Brook's LPN hours had been reduced to 32 hours a week. After these oral arguments, the Administrative Law Court issued an order remanding the appeal to HHS on July 30, 2012. On remand, the Court ordered the hearing officer to determine:

1. The weekly hours of registered nursing that are needed by the Appellant,

¹ DHHS has repeatedly assured the federal courts that the agency policy requires DDSN to continue services in effect at the time a state administrative appeal is filed. *Peter B. v. Sanford*, Case No. 6:10-cv-00767-JMC -BHH R&R dated November 24, 2010 (R. 114) and Order dated March 7, 2011 adopting the R&R.

taking into consideration the practical scheduling concerns of qualified providers in the geographical vicinity of the Appellant.

2. The specific type of care and the number of weekly hours of each type of care required by the Appellant during the course of her treatment since her discharge from the hospital in May of 2007 consistent with the Medicaid Program, and the principal that the mother is not legally responsible for caring for the Appellant.
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 Appellant to defray the cost of the more expensive device. See Record at 115.

The Office of Hearings and Appeals did not schedule a fair hearing until October 30 and

31. On December 9, 2012, Brook filed a motion requesting an interlocutory order and a proposed order. More than ninety days after the October hearing, DHHS announced that the hearing officer had been promoted to the position of chief and no final order on Brook's appeal filed more than six years ago, in 2007, has been issued. Exhibit 5.

While this appeal was pending, DHHS sent a notice of denial of payment for a DME supply or accessory. R. at 14. Brook filed a complaint on January 30, 2013 requesting that the record in Brook's pending appeal be supplemented with this latest denial and requested that those services be continued during her appeal. R. at 13. In response, instead of providing an evidentiary hearing, the DHHS hearing officer issued a "Pre-hearing Conference Order" on February 5, 2013. This Order required the parties to confer and to report a "summary of issues" and whether a resolution might be reached and required Petitioner's attorney to file a "statement of intention to continue the appeal process and to attend a Fair Hearing." R. 11. On March 19, 2013,

Petitioner's attorney responded by requesting a fair hearing, objecting to any order not based on evidence presented at the hearing and alleging that DHHS officials had shown conscious indifference to the risk of harm to Appellant by denying payment for the equipment.

Appellant requested an independent medical assessment of her need for the equipment at issue. R. 8. But, on April 4, 2013, the DHHS hearing officer issued an order dismissing Brook's appeal without providing a fair hearing. R. 1. This appeal followed.

Facts

Brook Waddle was injured in a car driven by another student on September 2, 2005 on the way to a high school event. Record at 857 to 859 and Exhibit 4. At the time of the accident, Brook was an honor student, a cheerleader and the homecoming queen for her high school. Record at 954 to 955 and Exhibit 4. Brook was the only passenger wearing a seat belt, however, her spine was crushed in the accident and she has quadriplegia. Brook is unable to speak due to an injury to her larynx subsequent to her spinal cord injury. It is undisputed that she requires assistance with all activities of daily living and she cannot be left alone in the residence.

Brook was transferred from Spartanburg Hospital to Shepherd Center in Atlanta on November 2, 2005, where she received rehabilitation until July of 2006. Respondent agreed to pay for out-of-state placement because the rehabilitation she needed was not available in South Carolina. Record at 860 to 861, 863. On January 25, 2006, the medical director of SCDHHS, Dr. Marion Burton, reviewed Brook's request for payment for out-of-state services, finding: "there are no rehab facilities in south carolina that accept patients on ventilators." Record at 863. However, Medicaid did not pay for these services Brook received in Georgia. Record at 153, 861

to 864. The only payment made by Medicaid between October 30, 2005 and July 1, 2006 was a wrist device costing less than \$100.00. Record at 913.

While at the Shepherd Center, Brook turned eighteen years old on January 14, 2006. Brook has no legal guardian and her parents had no legal obligation to provide for her care. In January of 2006, Brook first requested HASCI waiver services from SCDDSN. Record at 865. This request made its way from the local DSN Board to State DDSN offices to SCDHHS. Dr. Burton was informed of Brook's desire to receive services at home in April of 2006. Record at 123. Brook was never provided with a written denial of her request for services nor notice of her right to appeal. Fifty-seven nursing facilities were contacted in April and May of 2006, but none would agree to accept Brook. The best offer SCDDSN made to Brook before she retained legal counsel was to provide 20 hours a week of LPN services once she returned home. Record at 74 and 75.

Because no nursing homes in South Carolina or North Carolina would accept Brook, she was transferred on July 1, 2006 to MUSC in Charleston, which is nearly four hours from her home in Landrum. In September and October of 2006, at least seventy-three nursing homes were contacted, but none would accept Brook. Record at 841 to 851. Brook was transported on December 17, 2006 to New York where she underwent surgery. Record at 852 to 856 and 916. Respondent agreed to pay for Brook's surgery in New York, because there was no surgeon in South Carolina who could repair the damage to her vocal cords. Record at 852 to 856. Brook remained in New York until January 8, 2007, when she was transported back to MUSC in Charleston. Record at 123 to 125, 160.

When Brook returned to MUSC, Respondent sent a notice informing Brook that her Medicaid benefits were being terminated because it had been determined that she was no longer a resident of South Carolina. Record at 136. Brook was forced to retain a lawyer to reinstate her South Carolina Medicaid benefits. Record at 154. That is when Brook learned that she was entitled to receive more than 20 hours of services a week from the HASCI program.

In the spring of 2007, MUSC determined that Brook could no longer stay in the hospital. On March 29, 2007, Brook's treating physician at MUSC ordered 28 hours a week of RN services and 84 hours a week of LPN services, because she required suctioning throughout the day and night and she has to be turned every two hours. Record at 827. In addition to nursing services, Brooks treating physicians have ordered attendant care at all times when a nurse is not present. Id. Her physician in the hospital physician affirmed that Brook's parents were trained in all aspects of her care, including catheterization and suctioning. Id. See order at page 828 of the record.

Because Respondent at first refused to provide necessary services at home, Brook was involuntarily moved from MUSC to the "Old County Hospital" long term care unit. Record at 139 and 141. According to Brook's testimony "They - they called them the boat people because they just put you off on them." Record at 139. She was the youngest person who had ever been admitted to that unit. Id. One article described the transitional care unit as a "profit center." Id. The basic cost at the unit was more than \$11,000.00 a month, even before physician charges, respiratory therapy charges and ancillary charges were added. Record at 140.

Before Brook left the hospital, she was evaluated for a speech generating device by an independent speech and language pathologist and her physician prescribed the device.

(Respondent consented to written statements from Brook's physicians and health care providers being taken into evidence instead of presenting live testimony. Record at 1284.) Brook was nineteen years old. As a matter of law, she was undeniably entitled to EPSDT services because she was a Medicaid participant who was under age 21.

On April 17, 18 and 19, 2007, a qualified independent speech and language pathologist assessed Brook and determined in a seven page report that she needed a particular speech generation device. Record at 447 to 454. On April 24, 2007, an independent treating physician determined that Brook's request for a particular augmentative communications device was medically necessary. Record at 445. On April 25, 2007, a second physician not associated with the provider of this device, Pamela Pride, confirmed the medical necessity of the device that had been prescribed by Dr. Couco. The device would allow Brook to communicate with her caregivers and health care providers, as well as to communicate with her family and friends.

According to Dynavox, in March of 2006, Respondent began arbitrarily denying all requests for Medicaid coverage for these devices by determining that they were not medically necessary. Record at 849. SCDHHS began covering the devices again in August of 2008, however, SCDHHS soon thereafter reduced the reimbursement rate for these devices on October 1, 2008, effectively eliminating the device for Medicaid participants. Record at 849 to 850. On 14 April, 2009, Brook's treating physician reconfirmed the medical necessity for Brook to have the communications device. Record at 905 to 907. The SCDDSN service coordinator testified that Brook's budget included \$7,776.00 for "augmentative technology," but they never paid for

the device.² Record at 89.

In April of 2007, Protection and Advocacy for People with Disabilities and eleven individual plaintiffs filed a lawsuit against SCDDSN alleging that the agency had failed to promulgate rules and regulations about its policies and procedures for providing services as required by the Administrative Procedures Act. Record at 1258 to 1270. See <http://pandasc.org/wp-content/uploads/2011/07/COMPLAINT-DDSN-Regulations.pdf>.

This Court may take judicial notice that motions for summary judgment win this lawsuit ere heard in August of 2013.

When Brook returned home, Respondent had agreed to provide 44 hours of RN services or 60 hours a week of LPN services. She also received 28 hours a week of personal care services. Her physicians had determined that these services were not sufficient to meet her needs. In addition, DDSN required that these services had to be provided on a set schedule and that Brook could not carry over unused hours from week to week. Under the rules implemented in January of 2010, Brook could not use more than the allotted hours in any one day (by not using these hours on a different day.) Brook's plan of care stated that she required 24 hours a day of services. Record at 836. On May 9, 2007, Brook's attorney wrote to Respondent and SCDDSN asking that Brook be allowed to use the funds SCDDSN had budgeted for her LPN, RN and Personal Care Attendant services by using a flexible schedule that would allow Brook to use all of the services approved. Record at 979 to 980. No response was provided by Respondent.

² Brook purchased this device on credit, but that device is no longer functional or appropriate to meet her needs. Exhibit 1. Transcript of October 30-31, 2012 hearing. When Brook finally secured the device, she had been unable to talk to her health care providers, use the internet or phone her friends for three years.

The cost of Brook's care in the hospital was confirmed by the medical director for SCDHHS to be "about \$50,000.00 a month." Record at 122. The basic cost of Brook's care in the transitional care facility was \$11,400 per month, not including costs for physician care, respiratory and other ancillary services. Record at 979 to 980. The cost of her care during 92 days in the hospital was more than \$277,000.00. Id. See supporting documentation at pages 911 to 917 in the Record. Brook had been sent to Charleston, four hours from her home, because no nursing homes in South Carolina or North Carolina would accept her. In September and October of 2006, seventy-three nursing homes were contacted, but none would accept Brook. Record at 841 to 851.

After Brook's nursing and PCA services were reduced in 2010, pursuant to the illegal January 1, 2010 edict by DHHS, her health spiraled, requiring repeated hospitalizations beginning in March, 2010. (Medical records for all hospitalizations will be presented at the fair hearing.) She had to use oxygen again through her tracheostomy site for two days prior to admission in the hospital on March 10, 2010. She remained in the hospital that stay for eight days. Brook was diagnosed with pericardial effusion, which caused chest pain. Id. She had fluid on her lungs which caused shortness of breath. Her coumadin level was subtherapeutic when she was admitted. In May, 2010, Brook was treated at Greenville Hospital for pericardial disease. DCR at 50.

In January, 2011, Brook was again hospitalized at Greenville Medical Center with a grand mal seizure and swelling on her brain. (Service Coordinator note dated January 3, 2011 will be presented at the hearing). See also DCR at 72. Prior to her services being reduced in January, 2010 Brook had not experienced any seizures during the course of five years of

treatment post injury in 2005. Brook remained in the hospital from January 1, 2011 to January 9, 2011 and she suffered a hypotension episode while in the hospital.

In February, 2011, Brook notified her service coordinator of the need for a bariatric bed to prevent bed sores, but this medical equipment had not been provided at the time of Brook's evidentiary hearing in October of 2012. (Service Coordinator Notes dated February 1 and 7, 2011.) She was taken by ambulance to the emergency room on February 23, 2011 with convulsions. DCR at 53. Brook was hospitalized on February 28, 2011 and remained in the hospital until March 17, 2011 with anorexia, altered mental status and a UTI. She was in "a tremendous amount of pain" after another "hypotensive episode." Brook received treatment in March and April for pressure ulcers. Detailed Claims Report at page 46.

On April 20, 2011, Brook again suffered seizures at home and was admitted to ICU, where she was diagnosed with a MRSA infection. Upon admission, Brook suffered an altered mental status and a UTI. She remained hospitalized for nearly a month, until May 18, 2011. Due to the development of an abdominal hematoma, Brook's Baclofen pump was removed. She suffered acute blood loss, resulting in anemia. The hospital physician recommended continued home health an physical therapy, which has not been provided. Because of the lack of hours ordered by Brook's physician, her mother has been unable to provide for her care at home and to get her dressed and transported to therapy.

Brook was hospitalized for another week the end of February, 2012. Hospital records indicate a diagnoses of UTI, tachycardia and dehydration, with secondary diagnoses of cough, tracheostomy, chronic spasticity pain, quadriplegia, anemia, chronic anticoagulation, neurogenic

bowel and bladder. Hospital records report pneumonia, sepsis, a fever above 100 degrees at home, fatigue and altered mental status.

Brook was taken to the emergency room with a seizure that lasted fifteen minutes and pain from kidney stones on April 24, 2012. (SC Note dated April 24, 2012 will be presented at the fair hearing).

Brook was again admitted to the hospital on May 29, 2012 with a UTI, nephrolithiasis, iron deficiency anemia and depression, reporting pain, fever, chills and night sweats for two weeks. She remained in the hospital for three weeks. Brook made a follow-up request for the bariatric bed, which still has not been provided. On June 30, 2012, the service coordinator confirmed that she had received the prescription for the bariatric bed ordered by Brook's physician, but this bed has never been provided. (Service Coordinator Notes dated June 30, 2012 will be presented at the fair hearing).

Hearings were held on October 30 and 31, 2012 before hearing officer Elizabeth Hutto. Petitioner filed a motion for an interim order on December 9, 2013, but more than ninety days later, the hearing officer was promoted to the position of Chief Financial Officer for DHHS. No final order has been issued on Appellant's appeal. As predicted by the nurse who reviewed Brook's medical records and filed a Declaration in the October, 2012 hearing, Brook has been hospitalized for approximately six weeks subsequent to that hearing. (An opportunity to present this testimony was denied Brook because the Hearing Officer dismissed her appeal on April 4, 2013, without providing the evidentiary hearing required by 42 C.F.R. 431.200 et. seq.)

Arguments.

1. The issues raised in this appeal are encompassed in the complaint Appellant filed with DHHS on April 28, 2007 which included the issue of the failure of DHHS to provide services Brook needs to remain in her home, including but not limited to assistive technology and other services.

On April 28, 2007, Brook Waddle filed an appeal and a request for a fair hearing with DHHS requesting an evidentiary hearing, after the agency refused to provide Medicaid services which her physicians had ordered. Brook's appeal was not limited to a particular item or service, as her needs are ever changing and that appeal was sufficiently broad to encompass the denial of the oxymeter at issue in this proceeding. Brook has alleged in this proceeding that:

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 entitled to receive. The State has failed to offer these services to Brook Waddle with reasonable promptness.

Exhibit 1. In that appeal, Brook complained that "The State has acted erroneously in denying *requested services* in violation of applicable federal case law and regulations." Id. (Emphasis added.)

In the "Memorandum of Understanding" required by the hearing officer, Brook informed the hearing officer that her complaints about the failure to provide services, including, but not limited to assistive technology devices, had not been resolved and that DHHS failed to offer and provide necessary services with reasonable promptness. In the pre-trial brief the hearing officer demanded in 2007, Brook clearly advised Respondent that her appeal included, but was not limited to assistive technology devices and other services..." Brief dated September 10, 2007.

The issues raised in what DHHS considers to be this "appeal" are not new, but they

represent yet another violation by the agency of its ongoing violations of the reasonable promptness, reasonable standards and amount, duration and scope mandates contained in the Medicaid Act. The denial of services Brook needs, including assistive technology devices and other services, was appealed to this Court in a Notice of Appeal filed on December 17, 2007. Docket No. 07-ALJ-08-0626-AP. By the time this Notice of Appeal was filed, the executive branch was more than 150 days past the 90 day standard of promptness for issuing a final decision. 42 C.F.R. Now, more than six years has passed since Brook requested a fair hearing and a final decision to be issued within 90 days. 42 C.F.R. 431.244(f). But no final decision appealable to the judicial branch has been issued. Brook has been required to file many briefs, to present oral arguments before this Court and the DHHS hearing officers, and to file proposed orders during the past six years, but she has continued to be denied judicial review on her 2007 fair hearing appeal, in violation of her due process rights under the United States Constitution and the Medicaid Act and the separation of powers requirement of the South Carolina Constitution.

The agency and this Court have repeatedly recycled Brook's complaints within the executive branch, with conscious disregard for her health or the repeated lengthy hospitalizations required because DHHS has failed to assure that her health and welfare are protected. (42 C.F.R. 431.302(a) requires DHHS to provide CMS the "Assurance that necessary safeguards have been taken to protect the health and welfare of the recipients of the services.") Decisions to deny, reduce or terminate services have been based on binding norms established by agency employees without promulgation of regulations for the operation of the Medicaid program. *Hickey v. DHHS*, Docket No. 10-ALJ-08-0650AP (SCALC July 19, 2011).

Respondent takes the position that each time the agency denies a particular piece of equipment or supply, the Medicaid participant must pay additional filing fees and litigate yet another denial through the administrative "fair hearing" morass. But, Brook alleges that the denial of funding to pay for an oximeter cable falls within the "services" covered in her 2007 appeal.

Brook requests that this Court issue an order requiring DHHS to provide the services her physicians determine to be medically necessary, unless the ordered services are determined by a named licensed physician not to be so necessary. In that event, the physician determining that the services are not necessary should be required to provide a written denial specifically containing the medical justification for the denial, reduction or termination in services and this Court should order that a final administrative determination of medical necessity, appealable to the judiciary branch, must be provided within 90 days of Brook's request for a fair hearing.

2. **DHHS and this Court, as agencies of the executive branch of state government, have violated the separation of powers provision of the South Carolina Constitution, Brook's Constitutional right to due process, her statutory right to notices of the denial, reduction or termination of Medicaid services meeting the requirements of 42 C.F.R. 431.210, her right to an evidentiary hearing meeting the requirements of 42 C.F.R. 431.242 and 244 and her right to a final administrative decision within 90 days of her April 28, 2007 appeal by failing to rule upon all of the issues raised in her 2007 appeal and delaying her opportunity for judicial review for more than six years.**

The South Carolina Constitution provides in S.C. Const. art. I, § 8 that : "In the government of this State, the legislative, executive, and judicial powers of the government shall be forever separate and distinct from each other, and no person or persons exercising the functions of one of said departments shall assume or discharge the duties of any other." In this

case, the executive branch had an obligation to issue a final order within 90 days of Brook's request for a fair hearing. 42 C.F.R. 431.244(f) and *Doe v. Kidd I*, 501 F.3d 348 (4th Cir. 2007).

As the South Carolina Supreme Court recently held:

The preservation of a separation of powers has been a basic tenet of democratic societies at least since Baron de Montesquieu warned that "[t]here would be an end of everything, were the same man or the same body, whether of the nobles or of the people, to exercise those three powers, that of enacting laws, that of executing the public resolutions, and of trying the causes of individuals." *See* Montesquieu, *The Spirit of Laws* 152 (Thomas Nugent trans. 1949). Consistent with this notion, the South Carolina Constitution requires the branches of government be "forever separate and distinct from each other, and no person or persons exercising the functions of one of said departments shall assume or discharge the duties of any other." S.C. Const. art. I, § 8.

South Carolina Public Interest Foundation and Sloan v. South Carolina Transportation

Infrastructure Bank, 27266 (SCSC June 12, 2013). As the Court recognized in that case:

"One of the prime reasons for separation of powers is the desirability of spreading out the authority for the operation of the government." *State ex rel. McLeod v. Yonce*, 274 S.C. 81, 84, 261 S.E.2d 303, 304 (1979). "The legislative department makes the laws[,] the executive department carries the laws into effect, and the judicial department interprets and declares the laws." *Id.* at 84, 261 S.E.2d at 305. This delineation of powers amongst the branches "prevents the concentration of power in the hands of too few, and provides a system of checks and balances." *State ex rel. McLeod v. McInnis*, 278 S.C. 307, 312, 295 S.E.2d 633, 636 (1982).

Brook has been denied judicial review by the executive branch of government in this case, which has totally ignored her Constitutional and statutory right of due process and a final determination to be issued within 90 days of the request for a fair hearing. 42 C.F.R. 431.202(d) states that "The hearing system must meet the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970), and any additional standards specified in this subpart." DHHS has violated 42 C.F.R. 431.210 which requires specific content in notices of denial, reduction or

termination of services. The State Medicaid Agency has failed to provide an evidentiary hearing when her requests for services have been denied, in violation of 42 C.F.R. 431.220. DHHS and this Court have limited and interfered with her freedom to make a request for a hearing in violation of 42 C.F.R. 431.221. In clear violation of 42 C.F.R. 431.223, DHHS has dismissed Brook's requests for an evidentiary hearing. It has denied her procedural rights to an evidentiary hearing as established in 42 C.F.R. 431.242.

Finally, in contravention of 42 C.F.R. 431.244, the DHHS hearing officers have not based their decisions "exclusively on evidence introduced at the hearing" and have refused to allow Brook to present evidence in support of her allegations of violation of her Constitutional Rights, the Medicaid Act, the Americans with Disabilities Act and the South Carolina Administrative Procedures Act. This Court has failed to require DHHS to take corrective action in violation of 42 C.F.R. 431.246. The State has paid for its witnesses to be transported to the hearings and paid their salaries while waiting to testify and while testifying, while refusing to act upon Appellant's request under 42 C.F.R. 431.250 to pay for her witnesses to travel to and from the hearing and to pay for meeting the other expenses Brook has borne in connection with the hearings. DHHS has refused Brook's request to obtain an independent medical assessment as provided by 42 C.F.R. 431.240. (Transcript of October, 2012 hearing.)

DHHS and DDSN have violated the separation of powers prohibition by failing to promulgate regulations, as required by the South Carolina Administrative Procedures Act and by reducing, denying and terminating her services based on binding norms established by the agencies without promulgating regulations. *Hickey v. DHHS*, Docket No. 10-ALJ-08-0650AP (SCALC July 19, 2011); *Edge v. DHHS*, Docket No. 10-ALJ-08-0501-AP (SCALC October 29,

2010); *Eubanks v. DHHS*, Docket No. 10-ALJ-08-0502-AP (SCALC October 29, 2010); *Morgan v. DHHS*, Docket No. 10-ALJ-08-0503-AP (SCALC October 29, 2010).

The Preemption Clause of the United States Constitution prohibits DHHS from

dismissing Brook's appeal without providing a fair hearing meeting the requirements of

Goldberg and 42 C.F.R. 431.200 et. seq. The United States Supreme Court recently addressed

the issue of a State Medicaid Agency's violation of the Preemption Clause of the United States

Constitution. In *Wos v. E.M.A.*, North Carolina's Medicaid Agency attempted to enforce a state

Medicaid lien statute which conflicted with the anti-lien provisions of the Medicaid Act. 568

U.S. —, (U.S. Supreme Court March 20, 2013). Justice Kennedy wrote in his majority opinion

that "Where state and federal law 'directly conflict' state law must give way." Affirming the

decision of the Fourth Circuit, the Supreme Court ruled in *Wos* that:

Preemption is not a matter of semantics. A State may not evade the pre-emptive force of federal law by resorting to creative statutory interpretation or description at odds with the statute's intended operational effect.

That is exactly what DHHS and this Court have done in Brook's case. Many of the provisions of

the Medicaid Act are quite complicated and difficult to understand. The Act has been described

as "an aggravated assault on the English language, resistant to attempts to understand it."

Schweiker v. Gray Panthers, 453 U.S. 34 (1981). But, the requirements to provide a notice

meeting the statutory provisions of 431.210 and the simple requirement to give every Medicaid

participant a fair hearing who requests one is not in any way complicated or difficult to

understand. Yet, DHHS has a long history of flat out refusing to grant a hearing on the merits and

dismissing fair hearing appeals without complying with 42 U.S.C. 1396a(a)(3) or the

unambiguous requirements set forth in 42 C.F.R. 431.424 and 244.

In *Doe v. Kidd*, the plaintiff filed a lawsuit in federal court, thereby establishing Medicaid participants' right to bring a private action under 42 U.S.C. 1983 to enforce the "reasonable promptness" provision of the Medicaid Act, when DHHS dismissed her fair hearing appeal over Doe's objections without giving her an evidentiary hearing:

At the March 2003 hearing on DDSN's motion to dismiss, Doe conceded that DDSN had moved her to the top of the critical waiting list and had found her eligible for services under the waiver program earlier that month. Finding that all the appealed issues had already been resolved in Doe's favor, the DHHS hearing officer dismissed Doe's appeal.

501 F.3d 348 (4th Cir. 2007). In *Brown v. DHHS*, the South Carolina Court of Appeals reversed DHHS's decision and remanded Brown's case for a fair hearing after the DHHS hearing officer dismissed his appeal without providing an evidentiary hearing on the merits of his appeal:

Accordingly, the remainder of the order is vacated, and the case is remanded to DHHS for a hearing on the merits in accordance with this opinion and *pursuant to* 42 C.F.R. 431.220(a)(1)-(2).

709 S.E.2d 701, 705, 393 S.C. 11. (Emphasis added.) (This Court may take judicial notice that DHHS again, on remand, dismissed Brown's appeal without providing him with a fair hearing and this case is again pending before this Court.) In *Hickey, Edge, Eubanks, and Morgan*, DHHS dismissed the appellants' requests for a fair hearing and the agency was reversed by this Court, finding that the decision violated their right to due process and that the reductions in their services violated the South Carolina Administrative Procedures Act. *Supra*.

In this case, DHHS is fully cognizant that Brook has quadriplegia, requires suctioning and the administration of oxygen. Instead of providing an inexpensive attachment needed to measure Brook's oxygen level, the DHHS hearing officer issued an order requiring her attorney to confer

with the agency's counsel and then required the attorneys to file pre-trial briefs. Instead of providing a fair hearing and basing her order on "exclusively on evidence introduced at the hearing" - a very simple concept - the agency dismissed yet another request for a fair hearing in violation of 42 C.F.R. 431.223.

Appellant requests an order finding that she is the prevailing party in this action, ordering DHHS to comply with 42 U.S.C. 1396a(a)(3) and 42 C.F.R. 431.200 et. seq. and to provide services, equipment and supplies ordered by Brook's physicians with reasonable promptness, in the amount, duration and scope so ordered.

This is a matter of extreme public importance. In order to qualify for Medicaid, in most programs in South Carolina, the participant cannot own more than \$2,000 in liquid assets. For every participant who makes it through the hurdles imposed by DDSN and, then DHHS, there is a multitude of the most vulnerable citizens of our State whose have no access to justice and no ability to navigate their way through the executive branch to the Courts of this State. Not only do their lives hang in the balance, but taxpayers of this State are paying for expensive hospitalizations and institutionalization because DDSN is denying funding for medically necessary services, like a simple oxymeter.

3. **DHHS has violated its duty to assure that Brook's health and welfare are protected and it cannot deny critical services based on its provider, Apria, failing to provide its middleman, Kepro, with "supporting clinical evidence" when DHHS has extensive clinical records to support her need for an oxymeter cable.**

As a condition of accepting federal funding, as the State Medicaid Agency, DHHS has agreed to assure the health and safety of Medicaid waiver participants. 42 C.F.R. 441.302(a). It may not delegate to another entity the responsibility to exercise administrative discretion in the

administration or supervision of the State Medicaid Plan. 42 C.F.R. 431.10(e)(1). If other offices perform services for the Medicaid agency with respect to the application of policies, rules and regulations issued by the Medicaid agency, they may not substitute their judgment for that of DHHS. 42 C.F.R. 431.10(e)(3). The failure to provide equipment needed to measure Brook's oxygen level threatened her life and welfare, as has the failure to provide nursing services ordered by her physicians.

DHHS has violated its obligation to assure the health and safety of Brook and, in doing so, has placed her at tremendous risk of harm.

4. **DHHS has violated the reasonable promptness requirement of the Medicaid Act by failing to provide medically necessary services with reasonable promptness, in the amount, duration and scope necessary to prevent institutionalization and hospitalization, giving the greatest deference to the opinion of her treating physicians.**

The Medicaid Act requires DHHS to provide services with reasonable promptness. 42 U.S.C. 1396a(a)(8). See *Doe v. Kidd I and II*, supra and Case No. 10-1191 (4th Cir. March 24, 2011). The Fourth Circuit has interpreted "reasonable promptness to require that services be provided within 90 days." *Doe v. Kidd I* at footnote 3. In *Doe v. Kidd II*, the Fourth Circuit held "that Defendants violated Doe's rights under the Medicaid Act by failing to provide her with any of the residential habilitation services in a SLP II or CTH I setting, as authorized by DDSN and the 2003 plan, with reasonable promptness."

DHHS violated the directive of the United States Supreme Court in *Olmstead v. L.C.* by failing to give the "greatest of deference" to the opinions of Brook's treating physicians in determining what services are medically necessary. (Kennedy, J., concurring) ("The opinion of a

responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference.” 527 U.S. 581 (1999). Respondent has failed to demonstrate that it gave any deference to the opinion of Brook’s treating physician. Instead, as in *Moore v. Cook*, the state has based its decisions to deny, reduce and terminate Brook’s services based on “bureaucratic gobbledegook having no relation to her actual condition or needs.” 07-CV-631-TWT. In doing so, DHHS has violated the requirement of the Medicaid Act that the State provide services in the “amount, duration and scope” to “reasonably achieve its purpose, i.e. operating the HASCI waiver to delay or prevent institutionalization. 42 U.S.C. 1396a(a)(10)(A).

5. **DHHS has violated the Americans with Disabilities Act by denying, reducing and terminating services because Brook’s needs may be met in the least restrictive setting at home through reasonable accommodations which would not cause a fundamental alteration in the State’s system.**

Respondent DDSN is required by the ADA and *Olmstead*, as well as state law, to provide services in the least restrictive environment. *Doe v. Kidd*, 501 F.3d 348 (4th Cir. 2007), citing *Olmstead v. L.C.* 527 U.S. 581 (1999); S.C.Code Ann. § 44-20-20 (2006). The United States Supreme Court has determined that the burden of proving whether an action would cause a fundamental alteration under the ADA lies with the State. *Olmstead* at 603. Once a qualified individual proves her *prima facie* case in an action brought under the ADA, i.e. demonstrates that (1) she is a qualified person with disabilities, as defined in the ADA, (2) the State has determined that community based treatment is appropriate and (3) she does not oppose living in the community, then the burden shifts to the State to prove that providing the requested services would require a “fundamental alteration” in the nature of its programs. *Olmstead*, 527 U.S. at 604. Brook has clearly met her burden and she has requested reasonable modifications to the

MR/RD Medicaid waiver program, but Respondent has failed to prove, during the six years since Brook filed her 2007 appeal, that it would cause “fundamental alteration” for the State to provide the services she needs to live in the community.

In discussing the meaning of “fundamental alteration,” the plurality in *Olmstead* instructed the States that:

Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities.

Id. at 604. One way that the State may meet its burden by demonstrating that it has made reasonable modifications to its programs is to demonstrate that it has a comprehensive or effectively working plan to provide services in less restrictive settings:

If, for example, the State were to demonstrate that it had *a comprehensive, effectively working plan* for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met.

Id. at 605-606 (emphasis added). But, unlike most states, South Carolina does not have a comprehensive or effectively working *Olmstead* plan.

Prior to the amendment approved by Respondent, there were no caps placed on the number of days or hours of Respite Services a waiver participant could receive in her own home or in a community setting, outside of an institution. Before 2009, under the terms of the waiver, limitations on home-based Respite Services, PCA and Companion Services were based solely on medical necessity. (The waiver documents are contained in the Record of the DHHS hearing officer (who is now Chief Financial Officer of DHHS) that DHHS did not include in the “record”

provided in this appeal.) After the 2010 amendments, pursuant to the terms of the Waiver Document (which established binding norms without promulgation of regulations or approval of the legislature), any waiver participant who requires more hours than allowed under the caps had no choice but to enter a congregate residential program or be admitted to an ICF/MR for Respite care. Prior to these amendments, allocated hours were available to the waiver participant to be used on an annual, not monthly or weekly bases. Under the waiver amendments, if a waiver participant does not use the hours allocated for the week (PCA and Companion Services) or the month (Respite), they are forever lost. Any waiver participant needing more than 10 days a month, under any circumstances, would have no option but to submit to entering a DDSN institution. For example, in the event that an aging parent breaks a hip and requires 6 weeks of rehabilitation before she can resume providing supports in the home for her adult child, the only option would be to place the child in an institution for this care. It is uncontradicted that the risk of waiver participants entering an institution increased significantly by the Respite Service caps imposed in 2009, as demonstrated by the cost neutrality charts contained in Respondent's Waiver Documents.

Federal regulations at 42 C.F.R. 441.303 require the State to report to CMS the average cost per waiver participant as "Factor D" on the waiver application. These costs must be compared with "Factor G," which is the average cost of services if these participants were provided services in an ICF/MR. *Id.* In 2009, the average cost per MR/RD Medicaid waiver participant was \$36,209, according to the Waiver Document. According to the waiver application for 2010 (Year 1 of the amended waiver), the average annual cost per participant (Factor D) increased to \$44,232.12. R. 893. According to the Waiver Documents, which have not

been contested by the Respondent, this was an increase in costs of \$8,023.32 per waiver participant per year. *Id.*

Providing the services Brook's physicians have ordered would not cause an unreasonable financial burden on the State, and indeed that would likely save taxpayers money to avoid expensive hospitalizations. In any event, the *Olmstead* Court rejected a construction of the fundamental alteration defense that simply allows the State to compare the cost of the community services for the plaintiffs with the state's budget, and it declined to hold that relief that results in increased costs would constitute a fundamental alteration *per se*. *Id.* Instead, the Supreme Court directed, that the State must show that the request cannot "be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." *Id.* at 587, 607. DDSN and Respondent have "accommodated" other waiver participants who have extremely high needs without a fundamental alteration to its program through "outlier" funding.

In North Carolina, a federal district court judge granted emergency injunctive relief in 2010, prohibiting the state from reducing home-based services to persons who have a dual diagnosis of mental retardation and mental illness, just three days after the plaintiffs in that case filed their complaint alleging violation of the ADA. *Marlo M. Ex rel. Parris v. Cansler*, 679 F. Supp.2d 635 (E.D.N.C. 2010). The court determined that the plaintiffs, like Brook, were well integrated into the community and that it would be a violation of the ADA to reduce state funding that would force them into group homes or institutional settings. *Id.* See also *Ball v. Rogers*, No. 00-67 (D. Ariz. April 24, 2009) (holding that failure to provide plaintiffs with needed services "threatened Plaintiffs with institutionalization, prevented them from leaving

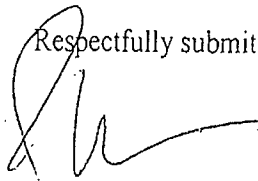
institutions, and in some instances forced them into institutions in order to receive their necessary care” in violation of the ADA and Rehabilitation Act); *Mental Disability Law Clinic v. Hogan*, No. 06-6320 (E.D.N.Y. Aug. 28, 2008) (“even the risk of unjustified segregation may be sufficient under *Olmstead*”); *M.A.C. v. Betit*, 284 F.Supp. 2d 1298, 1309 (D. Utah 2003) (adopting *Fisher*’s position that a plaintiff need not currently be institutionalized to bring integration regulation claim).

Conclusions

However complicated and convoluted other provisions of the Medicaid Act may be, Federal law is quite clear and unambiguous that an evidentiary hearing must be granted to any participant who requests one. 42 U.S.C. 1396a(a)(3) and 42 C.F.R. 431.200 et. seq. It is impossible for a Medicaid recipient to know each and every item DHHS will improperly deny while an administrative appeal is pending. In this case, despite the clear and unambiguous requirement that the State issue a final decision within 90 days, the executive branch of government has exceeded this standard of promptness by more than six years without providing Brook with an opportunity for judicial review.

Brook’s right to receive these services with reasonable promptness has been established by the Fourth Circuit in *Doe v. Kidd I and II*. This Court should issue an order granting the relief requested in his Brief and finding that Respondent has violated the Medicaid Act’s fair hearing requirements, the reasonable standards requirement and reasonable promptness mandate of the Medicaid Act, that Brook is the prevailing party in this case and that Respondent is required to pay legal fees and costs associated with this litigation.

Respectfully submitted,



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August 13, 2013

List of Exhibits

1. Transcript of October 30-31, 2012 hearing
2. Declaration of LPN Galus 267
3. Declaration of RN Hoover. 269
4. Photographs of Brook 279
5. DHHS news release announcing that hearing officer was promoted to Chief Financial Officer 282

1 HUTTO: We are on the record. This is a hearing concerning SCDHHS Division of
2 Appeals and Hearings, Case Number 07-Miscellaneous-028. This is an
3 administrative appeal brought by Brook Waddle. Today's date is October
4 25, 2012 and my name is Elizabeth Hutto. I will be the presiding officer
5 in this matter. I will conduct this hearing in accordance with the South
6 Carolina Administrative Procedures Act and the Department of Health and
7 Human Services Regulations 126-150 through 126-158. I will not make a
8 decision today. When I make my decision, both parties will be notified of
9 that decision in writing. The Petitioner is Brook Waddle who is
10 represented by Ms. Patricia Harrison and Mr. Ken?
11 ANTHONY: Uh-huh.
12 HUTTO: Ken, I'm sorry, Ken Anthony. The Respondent is the Agency, South
13 Carolina Department of Health and Human Services represented by Mr.
14 Hepfer. Others in attendance today are...
15 MOHAMED: Zaniha Mohamed.
HUTTO: Thank you. Linda...
17 VELDHEER: Linda Veldheer.
18 HUTTO: Linda Veldheer, thank you. Anita...
19 ATWOOD: Anita Atwood.
20 WATKINS: Lorraine Watkins.
21 WINGO: Ashley Wingo.
22 PETRUSKA: (Unclear) Petruska.
23 HUTTO: Thank you. And all of these are with the Respondent?
24 HEPFER: Yes ma'am.
25 HUTTO: And attending as observers today are Robert French and Betsy Schindler
26 who are also with the Division of Appeals and Hearings. So we have an
27 opportunity for opening statements and we have agreed that the
28 Respondent will go first. So would you like to give your opening
29 statement?
30 HEPFER: Well, I just very briefly want to put up some people from the HASCI
Division here and also from DDSN and actual service coordinator, current

1 service coordinator of Ms. Waddle, and then finally Ms. Zanipha
2 Mohamed of the Durable Medical Equipment Division here all to show
3 that what services were provided and what the Waiver limits were during
4 the time that Ms. Waddle received services under the HASCI Waiver.
5 And that's really all.

6 HARRISON:

7 Your Honor, our position is a little more complex than that. Our position
8 is that Brook Waddle, I think everyone agrees, has quadriplegia and
9 requires assistance with every activity of daily living. Initially 44 hours of
10 RN services were ordered and throughout this process, DDSN has used
11 binding norms rules that have not been promulgated as regulations which
12 violate the Medicaid Act and the ADA to deny her services that she needs
13 to live in the least restrictive setting in her home. They have not—we will
14 show they have not provided services in the amount, duration and scope
15 that is necessary to maintain her safety and also that they have contrary to
16 their own policy throughout this appeal while filing briefs with the
17 Administrative Law Court saying that her services were being maintained
18 at the 2007 level, they have consistently reduced her services without Ken
19 or I being notified that they were being reduced. We relied upon the briefs
20 that were being filed with the court. There's also the issue of the
21 communication's device that was ordered by her physicians, many
22 physicians, at least three physicians in 2007, I think perhaps 2006, the
23 payment for that device. And there's an issue of payment of Ms. Waddle
24 for the services that she provided because she was falsely informed that
25 the mother couldn't be paid for services for an adult. So we will be
26 presenting our position that these services have been reduced based on—
27 based on a continued practice that even after the Administrative Law
28 Court has told them over and over, you can't do that, you can't have these
29 caps without promulgating in these reg's, they have done so to Brook and
30 her—and other people in the Waiver. We would ask, Your Honor, we
would like to sequester the witnesses during the testimony. I mean once a

1 witness has testified I don't mind them being here but would like to
2 sequester the witnesses.

3 HEPFER: I don't see any reason for sequestering the witnesses. Ms.—I think it's
4 helpful for the witnesses to see how the testimony goes and get some—
5 particularly for these people who haven't testified before, get some idea of
6 how the—how a hearing like this goes and so forth so they'd be more at
7 ease during the—during their testimony and there's no—you know, we
8 don't have any secrets, there's—you're not going to learn stuff from other
9 people.

10 HUTTO: What is your reason for the sequestering?

11 HARRISON: Because the reasons given for different things are likely to be different
12 from different witnesses and if they hear from one, they'll parrot that one
13 versus another one. We have no objection to—someone from the Agency,
14 I assume Ms. Veldheer to be here representing the Agency but we think
15 these other witnesses should be sequestered just so they don't give
answers based on other witnesses' testimony.

17 HEPFER: Well, they have completely different perspectives of the case. For
18 example, Ms. Atwood is here at the Agency and does—and her testimony
19 is only going to be about oversight of the Waiver and changes during the
20 Waiver over time and Ms. Veldheer is the only representative from DDSN
21 here. The case worker—I mean the service coordinator, I keep saying
22 case worker, service coordinator is—has testimony regarding her direct
23 contact with Brook and there's no—I don't think she's going to learn
24 anything from the other testimonies and Ms. Mohamed is completely
25 separate from the Durable—in the Durable Medical Equipment
26 Department. She's only going to testify about that. I don't see any cross
27 learning that could take place.

28 ANTHONY: I can't think of any reason there would be not to sequester them.

29 HUTTO: I agree and they can all be nearby in the building so I don't think it will be
30 too difficult to sequester them.

HEPFER: Okay, where will they be?

1 HUTTO: Can they wait out there or they could go out to our Appeals area and
2 (unclear) to accompany one of them. Then I could text you right there.
3 HEPFER: Okay. All right. If you could tell us where they'll be and where they'll—
4 how they can be reached and Ms. Veldheer is going to stay, right?
5 HUTTO: Yeah. That would be fine.
6 HEPFER: And Ms. Veldheer can stay?
7 HUTTO: Yes sir, sorry, I think that would be fine.
8 HEPFER: Then, and Ms. (Unclear) you can go back here. I will need you but it will
9 be later. Thanks.
10 HARRISON: Is there—are we arranged okay for the witnesses? Will you be able to
11 talk...
12 HUTTO: I believe so. I have a good view of everybody (unclear).
13 HARRISON: Okay, I didn't know if the...
14 HUTTO: Robbie, would you do the swearing in? Do you mind?
15 FRENCH: Sure.
HUTTO: Mr. French will swear you in.
17 FRENCH: He was absent.
18 ATWOOD: Okay.
19 FRENCH: Do you have any religious beliefs that prevent you from swearing an oath?
20 ATWOOD: No.
21 FRENCH: Okay, would you raise your right hand? Do you swear to tell the truth, the
22 whole truth and nothing but the truth throughout your testimony?
23 ATWOOD: I do.
24 HEPFER: Okay. Ms. Atwood, would you say your full name for the Hearing Officer
25 and the others present and tell us what you do at the Agency?
26 ATWOOD: My name is Anita Atwood and I'm a Waiver Administrator at the
27 Department of Health and Human Services.
28 HEPFER: Okay, and what are your duties in that capacity?
29 ATWOOD: My duties are to be the administrative authority over the—to ensure
30 compliance with CMS and Federal Government and State Medicaid Policy
Rules and Regulations.

1 HEPFER: Okay.

2 ATWOOD: As well as—I mean I have other duties as well as providing renewal and
3 amendments to the Waiver document, enrolling and terminating the
4 HASCI Waiver participants and the Medicaid Management Information
5 Systems, reviewing and approving DDSN Waiver Policy, having meetings
6 with DDSN to make sure that they understand Medicaid Policy and any
7 changes.

8 HEPFER: Okay, and where do you get most of your direction in order to do that?

9 ATWOOD: CMS.

10 HEPFER: Okay. And what is—how long have you been doing it?

11 ATWOOD: I started this Agency March of 2009.

12 HEPFER: So you've been the HASCI Waiver Administrator since then?

13 ATWOOD: Yes sir.

14 HEPFER: Okay, and have you worked—what did you do before that?

15 ATWOOD: I worked for Department of Social Services. I was a Program Manager for
the homemakers. I was an Adult Protective Services policy writer, Child
17 Protective Services policy writer, trainer, served as a Case Manager in
18 Foster Care and Adult Protective Services, treatment, Child Protective
19 Services and also worked on our IT System as a Business Analyst.

20 HEPFER: How long have you worked for the State?

21 ATWOOD: Twenty-six years.

22 HEPFER: And how about your education? How are you qualified to perform these
23 tasks?

24 ATWOOD: I have a Master's Degree in Social Work. I'm a licensed Mastered Social
25 Worker.

26 HEPFER: Okay, thank you. Now how long has the HASCI Waiver been in force in
27 South Carolina, do you know?

28 ATWOOD: I'm thinking, the best of my knowledge I'm thinking fifteen, eighteen
29 years, close to twenty.

30 HEPFER: Okay. And how often are the waivers renewed?

ATWOOD: From what I recall from the initial document there's been three renewals.

1 HEPFER: Three renewals.
2 ATWOOD: Right. And those—the document's good for five years.
3 HEPFER: Okay, and plus the renewals, are there also other changes that take place in
4 the Waiver?
5 ATWOOD: Yes sir, amendments.
6 HEPFER: Amendments? Do you know approximately how many amendments
7 they've done?
8 ATWOOD: I can just say several but since I've been here, there's been three
9 amendments.
10 HEPFER: Okay. And when is the next renewal for the Waiver?
11 ATWOOD: It's upcoming. As a matter of fact we are in the process now of renewing
12 it. It is due submission to CMS in March and it's due in—it's up at the
13 end of June 2013.
14 HEPFER: All right. Now prior to July 2008, were there any limits that were imposed
15 upon the provision of nursing services and attendant care services?
ATWOOD: Not to my knowledge.
17 HEPFER: Okay. When did the first limits come into effect on those services?
18 ATWOOD: January 1, 2010.
19 HEPFER: Okay, what about—wasn't there a—wasn't there an amendment in July 1
20 of 2008?
21 ATWOOD: Okay, I wasn't here at that time. That was a renewal. It wasn't an
22 amendment.
23 HEPFER: A renewal. Okay. At that time?
24 HARRISON: Your Honor, Ms. Veldheer is shaking her head or...
25 HUTTO: Okay.
26 HARRISON: ...if we could ask that she not respond.
27 HUTTO: Yes, and Ms. Anita just indicated she wasn't here at that time but Ms.
28 Veldheer, if we need you for the time limit, we'll get you on that.
29 HEPFER: Right, you just testify what you know.
30 ATWOOD: Yes sir.
HEPFER: And so there was a renewal in July, on July 1, 2008.

1 ATWOOD: Yes sir.

2 HEPFER: And you don't recall whether that imposed limits or not?

3 ATWOOD: No sir.

4 HEPFER: Okay. You did mention that there was a renewal in January of 2010, is
5 that right?

6 ATWOOD: Yes sir.

7 HEPFER: And what limits were imposed on nursing and adult—I mean attending
8 care services at that time?

9 ATWOOD: Right. If I recall the attendant care we had, it was reduced from 60—56
10 hours to 49 so that would be 8 hours times 7 that's 56, and then 7 hours
11 times 7 is 49 and then a combination of attendant care and nursing it went
12 from, let me think, from 12 to 10 hours a day.

13 HEPFER: Okay.

14 HUTTO: This is per week?

15 ATWOOD: A day.

16 HUTTO: A day.

17 ATWOOD: Twelve hours a day. Yeah, when it's combined, attendant care and
18 nursing.

19 HEPFER: Okay, what about limits on respite services at this time?

20 ATWOOD: Let's see, now that didn't happen until (unclear). That was April 2011, I
21 believe.

22 HEPFER: All right.

23 ATWOOD: That was non-institutional respite care from daily to hourly.

24 HEPFER: Okay. And what about the number of hourly hours that a person could
25 have? Was that limited?

26 ATWOOD: No sir, not to my knowledge.

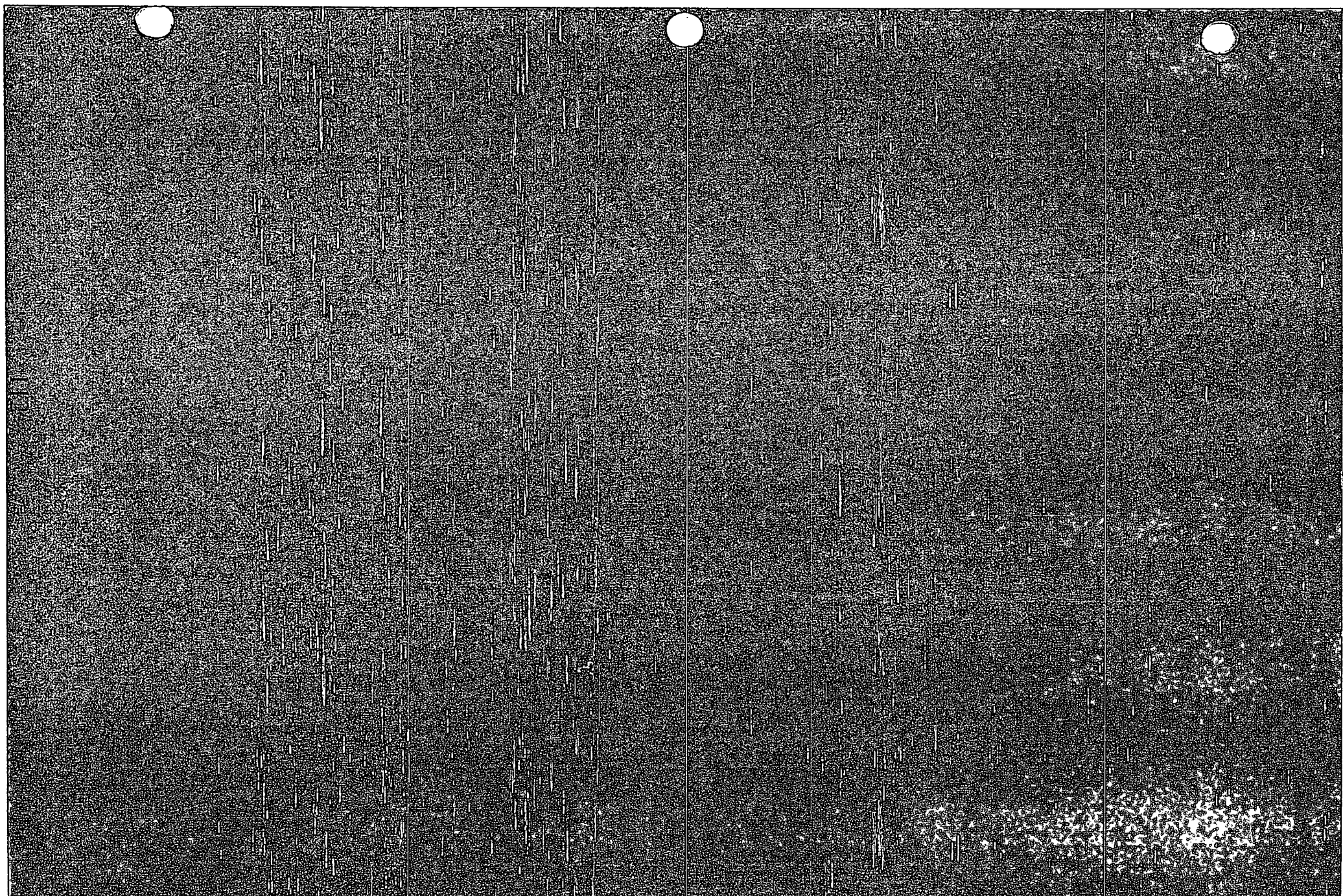
27 HEPFER: Okay. Do you know why the reductions took place?

28 ATWOOD: Yes sir, due to the State budget.

29 HEPFER: And anything else?

30 ATWOOD: Utilization was taken into consideration.

HEPFER: In other words, people were not using the services?



STATEMENT OF THE ISSUES ON APPEAL

1. The hearing officer's ruling that Appellant abandoned her appeal is the law of the case.
2. Appellant's arguments to this Court are not preserved for review.
3. Substantial evidence in the record supports the hearing officer's ruling.
4. Other issues raised by Appellant are without merit.

STATEMENT OF THE CASE

Appellant is a Medicaid eligible beneficiary, and Respondent is the single state agency charged with administration of South Carolina's Medicaid program. Appellant's provider submitted a prior authorization request for an oximeter cable, a piece of medical equipment. KePro, Respondent's agent who handles prior authorization requests of this type, denied the request because no supporting clinical information was submitted in support of the request. Appellant's provider was given 48 business hours to submit additional supporting documentation for the device but did not do so. The request was denied administratively for failure to supply the necessary information to allow KePro to make a prior authorization determination. (R.p.14).

Appellant appealed on January 31, 2013 with the Division of Appeals and Hearings. On February 5, 2013, the hearing officer issued a Prehearing Conference Order directing the parties to hold a prehearing conference and submit any remaining issues to the hearing officer. Appellant was also required to indicate whether she intended to continue pursuing an appeal. (R.p.11).

On March 19, 2013, Respondent submitted a letter setting forth the parties' conversation and indicating that the parties still disagreed as to whether the denial of the

oximeter cable was in error. Respondent noted its concern that Appellant was attempting to raise issues that were irrelevant to and outside the scope of the denial of the oximeter cable. However, Respondent deferred to Appellant in defining and setting forth her issues on appeal. (R.p.9).

Appellant also submitted a response on March 19, 2013. Notably, Appellant's response was submitted neither to the hearing officer nor Respondent's counsel. The response was instead submitted to Beth Hutto, the Director of the Appeals and Hearings Division and Third Party Liability;¹ Byron Roberts, Respondent's General Counsel; and Janet Goode, the hearing officer in one of Appellant's prior appeals, among others. Appellant's email containing her response to the Prehearing Conference Order included a request for a status report on a motion that was filed in 2012 in another proceeding between the same parties involving substantially similar issues. (R.p.5).

In her summary, Appellant asserted various violations of the Medicaid Act, the Americans with Disabilities Act (ADA), and the Rehabilitation Act of 1973. Appellant also re-alleged, "All allegations previously made by Appellant during the course of these proceedings and the appeal filed in 2007" Appellant then provided a lengthy description of various other appeals between Appellant and Respondent agency over the last several years. Appellant also requested that Respondent be required to pay for an independent medical assessment of Appellant at Appellant's convenience. (R.pp.6-8).

Once the email was forwarded to the hearing officer of record, Renee Johnson, Ms. Johnson replied to all parties on March 27, 2013, stating she thought there was "some confusion." She stated:

¹ Ms. Hutto is currently the Interim CFO for DHHS.

I believe it [the response] was meant to respond to my prehearing conference order (Appeals Case # 13-MISC-021) but it does not address the issue of my case (denial of a prior authorization of an oximeter cable for BW).

The hearing officer extended Appellant's opportunity to respond to April 2 and requested she include the documentation of medical necessity for the cable in her response. (R.p.5).

Merely hours after Ms. Johnson's email was sent, Appellant's counsel again emailed Ms. Hutto, Mr. Roberts, and Ms. Johnson among others on March 27, 2013, requesting Ms. Hutto, "please advise of the status of the hearing you presided over on October 30 and 31 and our emergency motion for an interim order." (R.p.3).

The hearing officer issued an Order on April 4, 2013, dismissing Appellant's appeal. The hearing officer noted in the Order that Appellant's initial response on March 19, 2013 "did not address the issues of this appeal and did not state the intention of continuing with this appeal." The hearing officer found that Appellant had been offered an extension to submit her response and statement of intention and had not done so by April 4, 2013. Therefore, the hearing officer found Appellant had abandoned the appeal and dismissed the appeal. (R.p.2).

Appellant filed an appeal with the Administrative Law Court (ALC). While Respondent was served with the Notice of Appeal on May 9, 2013, it appears the Notice of Appeal was not filed with the ALC until June 11, 2013. Marks on the front page of the Notice of Appeal indicate Appellant filed the Notice of Appeal with the Court of Appeals instead of the ALC. The Court of Appeals appears to have forwarded the Notice of Appeal to the ALC, which date stamped its receipt on June 11, 2013. A Notice of Assignment was issued on June 13, 2013. Respondent filed a Notice of Appearance on

June 25, 2013, and the Division of Hearings and Appeals filed a transcript on June 27, 2013.

ARGUMENT

I. Scope of Review – The “Substantial Evidence Rule”

This case is before the ALC as an appeal of an agency action. As such, the ALC sits in an appellate capacity under the Administrative Procedures Act (APA), rather than as an independent finder of fact. In South Carolina, the provisions of the APA – specifically S.C. Code Ann. § 1-23-380(5) – require a reviewing court to apply the “substantial evidence” rule. See e.g., Waters v. S.C. Land Resources Conservation Comm’n, 321 S.C. 219, 467 S.E.2d 913 (1996) and Palmetto Alliance, Inc. v. S.C. Public Service Comm’n, 282 S.C. 430, 319 S.E.2d 695 (1984).

A decision is supported by “substantial evidence” when the record as a whole allows reasonable minds to reach the same conclusion reached by the agency. Bilton v. Best Western Royal Motor Lodge, 282 S.C. 634, 321 S.E.2d 63 (Ct. App. 1984). The well-settled case law in this state has also interpreted the rule to mean that a decision will not be set aside simply because reasonable minds may differ on the judgment. Lark v. Bi-Lo, 276 S.C. 130, 276 S.E.2d 304 (1981). The fact that the record, when considered as a whole, presents the possibility of drawing two inconsistent conclusions from the evidence does not prevent the agency’s finding from being supported by substantial evidence. Waters, 321 S.C. 219, 467 S.E.2d 913 and Grant v. S.C. Coastal Council, 319 S.C. 348, 461 S.E.2d 388 (1995), both citing Palmetto Alliance, 282 S.C. 430, 319 S.E.2d 695. See also, Miller v. State Roofing Co., 312 S.C. 452, 441 S.E.2d 323 (1994) and Bilton, 282 S.C. 634, 321 S.E.2d 63 (Ct. App. 1984) and, in the PSC context, Kiawah

Property Owners Group v. Public Service Comm'n, 359 S.C. 105, 597 S.E.2d 145 (2004).

In applying the substantial evidence rule, the factual findings of the administrative agency are presumed to be correct. Rodney v. Michelin Tire Co., 320 S.C. 515, 466 S.E.2d 357 (1996), citing Kearse v. State Health and Human Services Finance Comm'n, 318 S.C. 198, 456 S.E.2d 892 (1995). Furthermore, the reviewing court is prohibited from substituting its judgment for that of the agency as to the weight of the evidence on questions of fact. Grant, 319 S.C. 348, 461 S.E.2d 388, citing Gibson v. Florence Country Club, 282 S.C. 384, 318 S.E.2d 365 (1984). Finally, the party challenging an agency action has the burden of proving convincingly that the agency's decision is unsupported by substantial evidence. Waters, 321 S.C. 219, 467 S.E.2d 913, citing Hamm v. AT&T, 302 S.C. 210, 394 S.E.2d 842 (1994).

Of course, the ALC may always reverse or remand a decision, which is affected by an error of law. Gilliam v. Woodside Mills, et al., 312 S.C. 523, 435 S.E.2d 872 (Ct. App. 1993), reversed on other grounds, 319 S.C. 385, 461 S.E.2d 818 (1995). However, in reviewing the errors of law asserted by the Appellant, the ALC does need to give deference to the Department's interpretation of its own rules and the relevant federal rules and manual provisions applied. Hampton Nursing Center v. State Health and Human Services Finance Comm'n, 303 S.C. 143, 399 S.E.2d 434 (Ct. App. 1990) and Ruocco v. S.C. Board of Registration for Professional Engineers and Land Surveyors, 314 S.C. 111, 441 S.E.2d 829 (Ct. App. 1994).

II. The hearing officer's ruling that Appellant abandoned her appeal is the law of the case

The hearing officer determined that Appellant had abandoned her appeal because, despite being given the opportunity to respond to the hearing officer and submit additional information, Appellant failed to do so. Appellant did not respond to the hearing officer's March 27, 2013 communication which requested she provide additional information regarding the pending appeal. As a result, the hearing officer ruled Appellant had abandoned the appeal request and dismissed the appeal. (R.p.2).

While Appellant has raised a variety of issues before this Court, Appellant neglected to appeal the determination by the hearing officer that Appellant had abandoned the appeal. See Toal, Appellate Practice in South Carolina 80 (2d ed. 2002) (citing Biales v. Young, 315 S.C. 166, 432 S.E.2d 482 (1993)) ("It is a fundamental rule of law that an appellate court will affirm a ruling by a lower court if the offended party does not challenge that ruling."); Id. ("Failure to challenge the ruling is an abandonment of the issue and precludes consideration on appeal."); Charleston Lumber Co. v. Miller Hous. Corp., 338 S.C. 171, 525 S.E.2d 869 (2000) (An order that is not appealed, whether right or wrong, is the law of the case.); ML-Lee Acquisition Fund, L.P. v. Deloitte & Touche, 327 S.C. 238, 489 S.E.2d 470 (1997) (citing In re: Morrison, 321 S.C. 370, 468 S.E.2d 651 (1996)) (an unappealed ruling is the law of the case, and the appellate court should not have considered the issue on appeal). Therefore, the hearing officer's conclusion that Appellant abandoned the appeal is the law of the case, and this Court should affirm the hearing officer's ruling.

III. Appellant's arguments are not preserved for review

Appellant has also raised multiple additional arguments in her brief to this Court. Appellant alleges that Respondent has denied her appropriate services, has not provided them with reasonable promptness, and various other statutory violations, among other claims.

These arguments were not raised to and/or ruled upon by the hearing officer. To the extent any of the issues were raised to the hearing officer, when an issue or argument has been raised to but not ruled upon by the trial court, a party must file a motion to alter or amend judgment to preserve the issues for appeal. See Rule 59(e), SCRCP; Elam v. S.C. Dep't of Transp., 361 S.C. 9, 24 n. 4, 602 S.E.2d 772, 780 n. 4 (2004). Because Appellant failed to raise or obtain rulings on these issues from the hearing officer, these arguments are not properly before or preserved for review by this Court. See Elam, 361 S.C. 9, 602 S.E.2d 772 (2004) ("Issues and arguments are preserved for appellate review only when they are raised to and ruled on by the lower court."); Wilder Corp. v. Wilke, 330 S.C. 71, 497 S.E.2d 731 (1998) ("It is axiomatic that an issue cannot be raised for the first time on appeal, but must have been raised to and ruled upon by the trial judge to be preserved for appellate review.").

Appellant failed to file a motion for reconsideration pursuant to Rule 59(e) raising these additional issues or to obtain a ruling on them from the hearing officer. Therefore, these issues are not preserved for review by this Court.

IV. Substantial evidence in the record supports the hearing officer's Order

The main issue of this appeal is whether substantial evidence in the Record supports the hearing officer's Order. Substantial evidence in the Record supports the

hearing officer's decision to find for Respondent. The hearing officer made several factual findings, all of which must be presumed correct, and this Court cannot substitute its judgment on the weight of the evidence. See Rodney, 320 S.C. 515, 466 S.E.2d 357; Grant, 319 S.C. 348, 461 S.E.2d 388.

Specifically, the hearing officer found that the correspondence received from Appellant on March 19, 2013 "did not address the issues of this appeal and did not state the intention of continuing with this appeal." Additionally, the hearing officer found that "Petitioner's attorney had not returned a response" to the prehearing conference order after being granted an extension. (R.p.2). Additionally, the record shows the hearing officer made clear that she sought to clarify "confusion" about the appeal at issue versus other ongoing litigation between the parties. In doing so, she provided Appellant an extension and a second opportunity to set forth her claims in this appeal, state her intention to proceed with the appeal, and provide any documentation of medical necessity. (R.p.5). Appellant failed to respond.

Fair Hearings

Appellant has argued Respondent erred in dismissing her appeal without a hearing. The Fair Hearing regulations that govern this matter are set forth at 42 C.F.R. § 431.200, et seq. The regulations implement §1902(a)(3) of the Social Security Act [42 USC §1396a(a)(3)], which requires the "...[s]tate to provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly." §431.200(a). The regulations further prescribe "...procedures for an opportunity for a hearing if the State agency ... takes action to suspend, terminate, or reduce services"

§431.200(b). “The hearing system must meet the due process standards set forth in Goldberg v. Kelly, 397 U.S. 254 (1970), and any additional standards specified in this subpart.” §431.205(d). The agency must grant an opportunity for hearing for a number of reasons, including for any recipient who requests one because he or she believes the agency has taken an action erroneously. §431.220(a)(2). The agency may deny or dismiss a request for hearing if: (1) the applicant withdraws the request in writing; or (b) the applicant fails to appear at a scheduled hearing without cause. § 431.223.

South Carolina’s regulations addressing fair hearings are 27 S.C. Code. Regs. 126-150, et seq. Specifically, Reg. 126-154 sets forth the authority of the hearing officer, who has:

Has the authority, among other things, to: direct all procedures, issue interlocutory orders; schedule hearings and conferences; preside at formal proceedings; rule on procedural and evidentiary issues; require the submission of briefs and/or proposed findings of fact and conclusions of law; call witnesses and cross-examine any witnesses; recess, continue, and conclude any proceedings; dismiss any appeal for failure to comply with the requirements under this Subarticle.

(emphasis added).

In Goldberg, the Court did not reach the issue of whether an opportunity for both written and oral argument must be afforded. Therefore, the Court left open the possibility that only an opportunity for a written argument is minimally required. See Goldberg, 397 U.S. at 268, n. 15. Additionally, while the U.S. Supreme Court has found that “due process . . . requires ‘the opportunity to be heard . . . at a meaningful time and in a meaningful manner,’” it has also recognized that “due process is flexible and calls for such procedural protections as the particular situation demands.” Rosen v. Goetz, 410 F. 3d 919 (6th Cir. 2005) (citing Mathews v. Eldridge, 424 U. S. 319 (1976)). In Rosen, the

Court found that requiring the petitioner to establish a valid factual dispute before being entitled to a hearing did not violate due process.

Similarly, in this case, Appellant was first given an opportunity to allege error, state an intention to continue with her appeal, and provide documentation of medical necessity by the hearing officer's Prehearing Conference Order. Appellant was also given additional time and another opportunity to allege error, state an intention to continue with her appeal, and provide documentation of medical necessity by the hearing officer on March 27, 2013.² Appellant failed to respond by the stated deadline of April 2, 2013. Therefore, her appeal was dismissed on April 4, 2013.

In South Carolina, due process requires an adequate opportunity for a hearing. S.C. Coastal Conservation League v. S.C. Dep't of Health and Environmental Control, 380 S.C. 349 (App. 2008), overruled on other grounds, 390 S.C. 418, 702 S.E.2d 246 (2010). However, as in Coastal, citing Zaman v. S.C. State Bd. of Med. Exam'rs, 305 S.C. 281, 408 S.E.2d 213 (1991), the Appellant "cannot complain of a due process violation if he has recourse to a constitutionally sufficient administrative procedure but merely declines or fails to take advantage of it." In Coastal, the party did not comply with the statutory time limits. In this case, the Appellant did not comply with the hearing officer's request to provide a statement of her intention or allege issues relevant to the case at issue.

Further, as to the hearing officer's authority to dismiss, the South Carolina regulations clearly state an intent to allow for dismissal of cases outside the two instances acknowledged in the federal law. Specifically, Reg. 126-154 states the hearing officer

² Appellant states several times (ie: R.p.22) that the parties were required to submit pre-trial briefs. No provision in the hearing officer's Order or March 27, 2013 communication asked for or required briefs. (R.p.5; p.11).

has authority to “dismiss any appeal for failure to comply with the requirements under this Subarticle.” Appellant clearly failed to comply with the hearing officer’s request to provide a statement of issues relevant to this appeal, a statement of intention, or the documentation showing medical necessity. Therefore, it was within the hearing officer’s authority to dismiss Appellant’s claim without a hearing.

Moreover, in the cases of Mims v. SCDHHS, Docket No. 07-ALJ-08-0082-AP (Adm. Law Ct. 2007) and Brown v. SCDHHS, Docket No. 12-ALJ-08-0067-AP (Adm. Law Ct. 2012), the Administrative Law Court discussed the limitations imposed on SCDHHS Hearing Officers by the Fair Hearing regulations at 42 CFR §431.223. The Court acknowledged that those regulations provide situations in which the Hearing Officers may dismiss appeals: (1) withdrawals by the Appellant; and (2) failure to appear. However, citing Sunset Cay, LLC v. City of Folly Beach, 357 S.C. 414, 593 S.E.2d 462 (2004), the Court found that the word “may” was permissive and not mandatory. Further, the Court found the federal regulation was not so comprehensive that the state hearing regulations, specifically 27 S.C. Code Regs. 126-154, which allowed for greater discretion of the Hearing Officers to dismiss appeals, could not be given effect.

Notably, in Mims, Appellant had been asked to provide further information in a hearing officer’s Order. He provided the additional information to the hearing officer approximately three weeks after the due date established in the Order. His appeal was dismissed for failure to comply with the hearing officer’s Order. In Brown, Appellant’s appeal was dismissed for failure to provide a more definite statement of the issues on appeal.

Similarly, in this case, Appellant was afforded the opportunity to present her statement of intention and allege error before the hearing officer. When it appeared there was confusion over the specific issues of this particular appeal, the hearing officer gave Appellant additional time and another opportunity to submit a statement of intention, set forth issues, and document medical necessity regarding the denied oximeter cable. Appellant failed to respond. Surely it makes practical and procedural sense that if Appellant is unresponsive and does not set forth a relevant cause of action or issue upon which the Hearing Officer can grant relief, then dismissal must be an option. In other words, if Appellant has been granted an opportunity for a hearing, but does not take steps to perfect the hearing, then she loses the opportunity.

V. Other Issues

Appellant has raised several other issues. Should the ALC find these issues preserved, Respondent briefly addresses them in turn.

A. Appeal from denial of oximeter cable

As stated above, the appeal rights in this case arose from the denial of a prior authorization request for an oximeter cable.³ There is no authority cited by Appellant or found by Respondent to regard this proceeding as anything other than involving the denial of an oximeter cable.

³ Appellant's claim that the notice of denial did not meet federal requirements is without merit. Appellant can show no prejudice from any alleged defects in the notice as she timely appealed and was provided an opportunity for hearing. See Palmetto Alliance v. S.C. Pub. Serv. Comm'n., 282 S.C. 430, 435, 319 S.E.2d 695, 698 (1984); Leventis v. S.C. Dep't of Health and Envtl. Control, 340 S.C. 118, 131-32, 530 S.E.2d 643, 650 (Ct. App. 2000) ("Further proof of a denial of due process in an administrative proceeding requires a showing of substantial prejudice.").

State Medicaid agencies can implement utilization controls to manage the provision of services and help ensure that only medically necessary services are being provided. These utilization procedures are considered and set forth in 42 C.F.R. § 440.230. Pursuant to that section, Medicaid agencies “may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. §440.230(d). Prior authorization is a type of utilization control procedure, and it is utilized by Respondent in a variety of contexts within the agency. Durable Medical Equipment (DME) is one such area where Respondent has elected to use a prior authorization procedure to ensure only medically necessary services are being provided. KePro currently processes the prior authorization claims for Respondent and processed Appellant’s request in this case.

Appellant’s chosen provider, Apria, failed to provide KePro with the appropriate documentation to make a prior authorization determination. Specifically, Appellant’s chosen provider neglected to include either clinical information supporting the request or a prescription for the oximeter cable. Apria was notified of the deficiencies and given 48 hours to provide additional documentation. Apria failed to do so. Without sufficient documentation to approve the request, KePro denied the request.

Respondent followed its policies and federal regulations in implementing and using utilization controls such as prior authorization. The failure to obtain the oximeter cable lies solely with the provider Appellant has chosen for services. Apria failed to submit the necessary documentation despite being prompted to do so. The procedure followed was not required only of Appellant or Appellant’s chosen provider, but is a policy utilized for several programs throughout the agency. Therefore, Respondent did

not err in its denial of Appellant's request. Notably, this issue and this appeal could still be easily resolved if Appellant's provider made another request with the necessary and requested supporting documentation included so that medical necessity could be determined.

Moreover, while Appellant seems to request carte blanche approval by Medicaid for whatever treatment or devices she desires, such discretion is not contemplated by Medicaid law. While courts do give weight to the treating physician's discretion, it has been recognized that both the treating physician and the state have roles to play in determining medical necessity. See Rush v. Parham, 625 F.2d 1150, 1156 (5th Cir. 1980). Moreover, the treating physician's word on medical necessity is not dispositive. Moore v. Medows, 324 Fed.Appx. 773 (11th Cir. 2009). The State may place limits on a physician's discretion such that "[t]he physician is required to operate within such reasonable limitations as the state may impose." Rush v. Parham, 625 F.2d at 1156. A state Medicaid agency can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis. Rush, 625 F.2d at 1155. Therefore, Respondent agreeing to provide whatever Appellant's physicians or family deem necessary would be inappropriate and in violation of federal law.

Should the Court decide this issue has been preserved and wishes to address it, Respondent respectfully requests it be allowed to supplement the record with a more clear and complete copy of the KePro denial. (R.p.14). The copy included in the Record was submitted by Appellant and is dark with poor contrast and does not include the second page which contained Appellant's appeal rights. (R.p.14).

B. Final decisions within 90 days

Appellant argues that Respondent has violated federal law by not issuing a decision in this appeal or the other pending appeal involving the same parties and issues. Appellant refers to the discussion of a 90-day standard in 42 C.F.R. § 431.244(f).

Appellant's assertions are without merit. First, the federal regulation states that "ordinarily" decisions should be rendered within 90 days of the date Appellant filed for direct access to a state fair hearing. § 431.244(f)(1)(ii). From its very language and use of the qualifier "ordinarily," it is clear the regulation acknowledges there are situations where final agency determinations may not be able to be made within the 90 day window. To interpret the regulation otherwise ignores its plain meaning and dismisses the use of the word "ordinarily." Given a variety of issues that face parties in proceedings before the agency, including but not limited to discovery, prehearing discussions, and coordinating schedules of various experts needed for testimony, it is not unusual for final determinations and hearings to stretch past the 90 day mark. Often one or both parties request a continuance which complicates compliance with the 90-day mark. For those and other reasons, it makes logical sense that there would not be a hard deadline imposed on such proceedings when circumstances call for additional time.

Moreover, Appellant filed this appeal on January 31, 2013 (R.p.1). The hearing officer's Order was dated April 4, 2013, 63 days after an appeal was requested, and well within the contemplated 90-day period. There appears to be confusion regarding what constitutes a final administrative action or final decision or final order. Statutes governing the ALC's appellate jurisdiction state that an appeal can be taken to the ALC from a "final decision." S.C. Code § 1-23-600(E). Because Appellant did not file a Rule

59(c) post-trial motion, the hearing officer's order was and remained a final judgment. Coward Hund Const. Co., v. Ball Corp., 336 S.C. 1, 518 S.E.2d 56 (Ct.App. 1999) (basing the commencement of the time period for appeal on the finality of a judgment)). Had the hearing officer's Order not been final, Appellant would have been unable to appeal this Order to the ALC. Simply because Appellant has continued to challenge various rulings or the ALC has remanded to the hearing officer for determinations to be made on certain issues does not mean the intervening hearing officer and ALC orders have not been final judgments.⁴

C. Promulgate regulations

Appellant argues that Respondent has erred in not promulgating regulations in this scenario and cites several ALC cases for support. However, these cases are distinguishable from the case at hand. First, those cases involved Respondent's waiver programs. The case at hand involves a prior utilization procedure involving state plan services. Second, the cases Appellant cites involve across the board limits on services for individuals participating in the waiver. For example, limits were set on personal care or nursing services hours in a week. In this case, no across the board limitation was imposed that limited the oximeter cable's access by Appellant. Instead, Appellant's provider failed to provide sufficient information so that KePro could make a medical

⁴ Similarly, Appellant's argument that the separation of powers has been violated is without merit. Respondent's Appeals and Hearing Division has jurisdiction over the case initially; per law, that jurisdiction now lies with the Administrative Law Court. Due to remands and appeals from subsequent decision of the agency's hearing officers, the appeals have proceeded no further than the ALC. However, this is the nature of the course of this particular case, and Respondent has not been denied of her eventual ability to appeal to the Court of Appeals or Supreme Court when it is appropriate and should she pursue her appeal to that extent.

necessity determination. This scenario is not one in which promulgating regulations is either necessary or required.

D. Legal fees and costs

Appellant has requested an award of legal fees and costs. It is unclear for which proceedings or for which appeal Appellant is seeking fees and costs. Any requests for fees and costs for the proceedings before the agency and its hearing officer are improper. McDowell v. SCDSS, 304 S.C. 539, 405 S.E.2d 830 (1991) (award for attorney's fees for DSS hearing improper).

Further, if Appellant is requesting fees pursuant to § 15-77-300, it states:

(A) In *any civil action* brought by the State, any political subdivision of the State or any party who is contesting state action, unless the prevailing party is the State or any political subdivision of the State, the court may allow the prevailing party to recover reasonable attorney's fees to be taxed as court costs against the appropriate agency if:

- (1) the court finds that the agency acted without substantial justification in pressing its claim against the party; and
- (2) the court finds there are no special circumstances that would make the award of attorney's fees unjust.

(emphasis added).

The statute at issue applies to civil actions, which do not include administrative proceedings.⁵ Additionally, Respondent's posture in this proceeding is as a defendant. Appellant is and has been the party "pressing its claim," not Respondent. Finally, there is evidence in the record and otherwise showing Respondent acted with substantial

⁵ Notably, the Legislature has considered but failed to pass amendments to § 15-77-300 to include attorney's fees and costs for contested administrative proceedings. See H. 3383, 112 Leg., 1st Sess. (1997). First, this indicates an award pursuant to this section is not currently proper or intended for administrative proceedings before the ALC. Second, these amendments only indicated a willingness to expand awards to contested cases before the ALC, not administrative appeals from agency determinations.

justification in denying Appellant's request administratively. As stated and cited above, Respondent is granted authority and encouraged to use utilization controls, such as prior authorization procedures, by federal law. This process ensures that the services being provided are not repetitious or unnecessary, among other concerns. This process was conducted in accordance with Respondent's policies and procedures. Appellant's chosen provider failed to provide the information necessary for KePro to make a medical necessity determination as to the oximeter cable. Therefore, Respondent acted properly in its denial and has acted with substantial justification in defending that decision.

VI. Conclusion

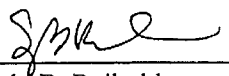
For the reasons set forth above, the hearing officer's determination should be upheld. The hearing officer's conclusion that Appellant abandoned the appeal was not appealed and is the law of the case. The majority of issues raised in Appellant's brief are not preserved for review. To the extent the issue of dismissing the appeal without hearing may be preserved, substantial evidence exists in the Record to uphold the hearing officer's ruling in favor of Respondent. The record shows Appellant abandoned her appeal by failing to respond to an Order to set forth relevant issues in the case despite being granted additional time and an additional opportunity to do so. Respondent was within its authority to dismiss Appellant's appeal without hearing based upon federal law, state regulation, and prior rulings by the Administrative Law Court. Therefore, the hearing officer's determination should be upheld.

As stated in Respondent's motions, dismissal in whole or in part of Appellant's case is also warranted. Appellant failed to file her Notice of Appeal in a timely manner,

violating ALC rules and divesting the Court of jurisdiction to hear the appeal. Additionally, by her own admission, Appellant's claims are the same or substantially similar to those raised in another pending proceeding between the same parties. Therefore, dismissal is appropriate on a number of grounds.

Should the Court find that remand and a hearing before the hearing officer is appropriate, Respondent respectfully requests the Court limit consideration by the hearing officer on remand to issues surrounding the denial of the oximeter cable.

Respectfully Submitted,



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September 11, 2013
Columbia, South Carolina

PLH Cory

IN THE STATE OF SOUTH CAROLINA
IN THE SOUTH CAROLINA ADMINISTRATIVE LAW COURT

Docket No. 13-ALJ-08-0267-AP

B.W. II,
Petitioner,
v.

South Carolina Department of
Health and Human Services,
Respondent.

APPELLANT'S AMENDED REPLY BRIEF

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FILED
SEP 25 2013

Waddle requested a fair hearing on January 30, 2013 when Respondent denied her request to pay for an oximeter cable that had been ordered by her physician. R. at 2. Respondent admits that this equipment was denied “administratively” because its agent, KePro, did not obtain “supporting clinical information” within 48 hours. Instead of providing an evidentiary hearing to Waddle, as she requested on January 30, 2013, on February 5, 2013, the DHHS hearing officer issued an order requiring Appellant’s counsel to participate in a “pre-hearing conference.” Appellant’s counsel participated in the “pre-hearing conference.” In addition to participating in this “pre-hearing conference,” the hearing officer required Appellant to “submit a summary of issues discussed” and “any additional information that will be submitted at the hearing or requests that either party anticipates making.” In the order, the DHHS hearing officer informed Appellant that “a hearing will be scheduled depending upon the Hearing Officer’s calendar.” R. 11.

On March 19, 2013, Appellant filed a formal written response to the hearing officer’s order titled “Appellant’s Response to Order” in which Waddle again requested an evidentiary hearing and a final determination within 90 days of her request for a hearing. R. at 6. She requested that the hearing officer schedule a hearing and that she base her decision exclusively on evidence presented at the evidentiary hearing, as is required by federal law at 42 C.F.R. 431.244(a). R. 6. (“Hearing recommendations or decisions must be based exclusively on evidence introduced at the hearing.” Id.) In her response, Appellant complained that DHHS improperly denied equipment, services and supplies that are medically necessary. R. at 6. She alleged that DHHS violated other provisions of the Medicaid Act, the Americans with Disabilities Act (ADA), the Rehabilitation Act of 1973 and the South Carolina Administrative

Procedures Act. Id. at 6 to 7. Appellant also incorporated allegations in the 2007 complaint into her response and requested an independent medical evaluation of her need for the oximeter cable.¹ R. at 8. But the hearing officer did not appoint an independent medical examiner and no evidence was introduced by Respondent contradicting the claim made by Waddle that the device is medically necessary. (Because the required hearing was never held, the record on appeal does not include an order or declaration of Waddle's physician.)

The DHHS Office of Hearings and Appeals clocked in this Response in the mail on March 22, 2013. R. at 6. But an email from Waddle's counsel indicates that this response was actually provided electronically to DHHS and the Office of Appeals and Hearings via email on March 19, 201. Instead of scheduling a fair hearing, the DHHS hearing officer sent an email requesting additional documentation on March 27, 2013 at 10:17 a.m. At 12:43 p.m. - less than three hours later - Appellant's counsel responded to Ms. Johnson's email. R. at 3. In this response, counsel for Waddle complained that 270 days had passed since the South Carolina Administrative Law Court remanded Brook's case, but no order had been issued.² R. 3.

(Appellant sent this email to both the DHHS Hearing Officer and the Director of the DHHS

¹ 42 C.F.R. 431.240(b) provides that "If the hearing involves medical issues such as those concerning a diagnosis, an examining physician's report or a medical review team's decision and if the hearing officer considers it necessary to have a medical assessment other than that of the individual involved in making the original decision, such a medical assessment must be obtained at agency expense and made part of the record."

² Actually, more than 2,300 days have passed since Waddle filed her first request for a fair hearing in 2007, but no final administrative agency decision has been issued in that appeal and her case has languished for more than six years in the Executive Branch without opportunity for judicial review. As admitted by Respondent in their brief, the hearing officer who most recently heard Waddle's appeal (on remand from this Court) was promoted to be the interim financial officer for DHHS without issuing a ruling pursuant to Judge McLeod's remand order. Respondent's Brief at fn. 1 on page 3.

Office of Hearings and Appeals. Id.) Waddle had already addressed issues raised by the hearing officer in her formal written response to the hearing officer's order - by responding that federal law requires DHHS to provide an evidentiary hearing. The hearing officer's repeated demands to lay out her case for the agency's benefit before the hearing through pre-trial written responses was not only prejudicial to Appellant, but those demands violated federal law, which require an evidentiary hearing and the decision to be based *exclusively* on evidence presented at the hearing. 42 C.F.R. 431.244(a). 42 C.F.R. 431.244(e) requires a final decision within 90 days.

On April 4, 2013, the hearing officer dismissed Waddle's appeal because "Petitioner's attorney has not returned a response to this Hearing Officer's Pre Hearing Conference Order." R. at 2. Waddle's response to the Pre Hearing Conference Order was clocked in by DHHS on March 22, 2013. R. at 6.

At no time did Waddle withdraw her request for a hearing - in writing or otherwise. 42 C.F.R. 431.223(a). She did not fail to appear at a scheduled hearing. 42 C.F.R. 431.223(b). The hearing officer violated the clear directives of 42 C.F.R. 223 by dismissing Waddle's appeal.

Federal Law Preempts the Dismissal of Waddle's Appeal

As the federal district court ruled in *Meacham v. Wing* providing an evidentiary fair hearing is mandatory, not precatory:

42 U.S.C. § 1396(a)(3) provides that the "State plan for medical assistance *must* --... (3) provide for granting an opportunity for a fair hearing...." (emphasis added). The implementing regulations use similar language. *See, e.g.*, 42 C.F.R. § 431.205(d) ("The hearing system *must* meet the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970) and any additional standards specified in this subpart") (emphasis added); 42 C.F.R. § 431.244(a) ("Hearing recommendations or decisions *must* be based exclusively on evidence introduced at the hearing ...") (emphasis added).

77 F. Supp. 2d 431 (S.D.N.Y. 1999). As the federal district court in Delaware held in *Ortiz v. Eichler*, federal regulations “provide that claimants have the right to examine all documents used by the agency and refute any evidence, and to confront and cross-examine adverse witnesses.” See 45 C.F.R. § 205.10(a)(13)(i); 42 C.F.R. § 431.242(a), (e); 7 C.F.R. §§ 273.15(p)(1), (5), 273.16(e)(2)(ii). 616 F.Supp. 1046 (D. Del. 1985). That court noted that “The two reported cases interpreting these provisions have followed their clear meaning and have found that a procedural violation occurs when the decision maker bases his or her decision on evidence or analysis not presented at the hearing.” Citing *Featherston v. Stanton*, 626 F.2d 591, 595 (7th Cir.1980); *Persico v. Maher*, 191 Conn. 384, 465 A.2d 308, 322 (1983); cf. *Lonzollo v. Weinberger*, 534 F.2d 712, 714 (7th Cir.1976) (Social Security disability case); *Gullo v. Califano*, 609 F.2d 649, 650 (2d Cir.1979) (per curiam) (same); *Generella v. Weinberger*, 388 F.Supp. 1086, 1090 (E.D.Pa.1974) (same).

Respondent’s argument that S.C. Code Regs. 126-154 grants a DHHS Hearing Officer the authority to dismiss a Medicaid fair hearing without providing an evidentiary hearing contradicts federal law and South Carolina is preempted from dismissing a fair hearing based on any reason other than the Appellant withdrawing her appeal in writing or failing to appear at a scheduled hearing. 42 C.F.R. 431.233. Federal law is quite clear that the DHHS hearing officer must base fair hearing decisions “exclusively” on evidence presented at an evidentiary hearing at which the Medicaid participant must be given the opportunity to present witnesses and to cross examine the State’s witnesses. 42 C.F.R. 431.244(a). The hearing officer violated federal law by dismissing Waddle’s appeal. As is required by the Supremacy Clause of the United States Constitution, state regulations provide at S.C. Reg. § 126-399, titled “Conflict Between State and Federal

Regulations” that “When the requirements of the State and the Federal regulations are not in agreement, the requirements of the Federal regulations shall prevail.” In addition, S.C. Reg § 126-158, titled “Hearing Procedures,” provides that “All parties to an appeal shall have the right to be represented by counsel, call witnesses, submit documentary evidence, cross-examine the witnesses of an adverse party, and make opening and closing statements.” It is uncontradicted that Waddle was not provided an opportunity to call witnesses, to cross-examine the State’s witnesses or to make oral opening and closing statements. DHHS violated not only federal law in dismissing Waddle’s appeal, but Respondent violated these state regulations as well.

Respondent’s argument that Appellant provided her March 19, 2013 response to “neither the hearing officer nor Respondent’s counsel” is also not supported by the record. An email dated March 19, 2013 transmitted the response to general counsel for DHHS and the Director of the DHHS Office of Appeals and Hearings. R. at 5.

Rule 204(a) required the Court of Appeals to transfer Waddle’s appeal to the correct court.

The order dismissing Waddle’s appeal was received by Appellant’s counsel on April 9, 2013. A notice of appeal was filed on May 9, 2013. Appellant’s counsel sent a runner to the address of the South Carolina Administrative Law Court at the Edgar Brown Building at 1205 Pendleton Street, where the Notice of Appeal was clocked in by a clerk and a check for \$100 was left with the clerk. The check made out to the Administrative Law Court was cashed on May 15, 2013. (Although the DHHS Office of Appeals and Hearings did not include this Notice in the Record on Appeal, this Court may take judicial notice that the Notice of Appeal was clocked in on May 9, 2013, within the requisite time for filing an appeal.) Unfortunately, the South

Carolina Court of Appeals had set up a temporary desk in the same building as the South Carolina Administrative Law Court at 1205 Pendleton Street and neither the runner nor the clerk noticed that the caption for the appeal was in the Administrative Law Court, not in the Court of Appeals. As provided in South Carolina Rules of Appellate Practice, when a notice of appeal is filed in the wrong court, the appellate court must transfer the appeal to the correct court.³

As the South Carolina Court of Appeals held in *McDowell v. South Carolina Dept. of Social Services*, when a filing is made in the wrong court, the receiving court must transmit the filing to the correct court and the action shall not be dismissed. 300 S.C. 24, 386 S.E.2d 280, 282 (S.C.App. 1989). That Court ruled that such filing do not prejudice the rights of litigants:

S.C.R.CIV.P. 82(b) ("When an action is brought in the wrong ... court, the court shall not dismiss the action but shall transfer it to ... [the] court in which it could have been brought." DSS demonstrated no prejudice; therefore, the petition, though captioned in the Court of Appeals, was not, as the court below characterized it, "deficient." 71 C.J.S. Pleading Sec. 547 at 1111 (1951) ("[T]he courts should not regard seriously objections to the pleadings, more technical than real, which do not operate to the prejudice of the substantial rights of a litigant.").

Id.

DHHS is not prejudiced by Appellant's filing the Notice of Appeal at the desk in the lobby of the Brown Building at 1205 Pendleton Street and the South Carolina Court of Appeals complied with Rule 204(b) and transferred the appeal to this Court. Respondent's arguments that this Court is without jurisdiction to hear this appeal contradict this Rule.

Medicaid Fair Hearing Appellants are not required to file a motion to reconsider when a hearing officer violates federal law by dismissing an appeal without providing an evidentiary hearing.

³ Rule 204(b) is mandatory, stating that the receiving court "shall issue an order transferring the case to the appropriate court."

There is no legal basis to require a Medicaid participant to file a Rule 59(e) motion before filing an appeal in the South Carolina Administrative Law Court. Indeed, such motions are not even a prerequisite for filing an appeal from this Court (also in the Executive Branch) to the South Carolina Court of Appeals. Administrative Law Court Rule 40. The letter to Waddle's counsel from the Chief Hearing Officer of the DHHS Office of Hearings and Appeals instructed Waddle to file her appeal within 30 days of receipt of the order with the South Carolina Administrative Law Court. Respondent's argument that this Court should uphold the dismissal of her fair hearing appeal for failure to file a Rule 59(e) motion is frivolous. Mandates requiring compliance with Rule 59(e) clearly apply only to courts within the Judicial Branch.

The DHHS Hearing Officer's dismissal order was not supported by substantial evidence.

Respondent's argument that "substantial evidence" supports the hearing officer's order is likewise frivolous. But, federal law provides that a hearing officer's decision must be based on evidence "introduced at the hearing." 42 C.F.R. 431.244(a). Thus, not only did the hearing officer lack substantial evidence to support her decision, there is no evidence upon which the hearing officer could have legitimately based her order, since she refused to schedule a fair hearing.

Respondent has violated the due process rights of Waddle.

The United States Supreme Court addressed the issues raised by Respondent in *Goldberg v. Kelly*, 397 U.S. 254 (1970). In that case, the Supreme Court held that applicants for government benefits are entitled to an oral hearing before an impartial decision-maker, the right to confront and cross-examine witnesses, and the right to a written opinion setting out the

evidence relied upon and the legal basis for the decision. Id. The procedural rights Waddle possesses are clearly set forth in 42 C.F.R. 431.242 and 244. These rights include the right to bring witnesses, to present her argument at an evidentiary hearing without undue interference, to cross examine the State's witnesses and to question or refute any testimony or evidence presented by the State at an evidentiary hearing.

Respondent refers to *Mims v. SCDHHS*, Docket No. 07-ALJ-08-0082-AP (ALC 2007) and *Brown v. SCDHHS*, Docket No. 12-ALJ-08-0067-AP (ALC 2012) in support of their arguments that DHHS can dismiss the appeals of Medicaid participants without providing a fair hearing. Appellant's counsel believes that Respondent may have been obligated to inform this Court that after this Court dismissed Mims' appeal without requiring DHHS to provide a fair hearing, Mims subsequently opted to file an action in the Circuit Court, rather than to pursue his remedy through the futile administrative appeals process.⁴ The Circuit Court dismissed Mims' civil lawsuit, but the South Carolina Supreme Court reversed the circuit court's dismissal of his lawsuit and Mims' case was remanded back to the circuit court for trial. *Mims v. Babcock Center*, 399 S.C. 341, 732 S.E.2d 395 (S.C. 2012). Motions for summary judgment in that case are pending before Judge Thomas Cooper. Mims' decision to not pursue futile administrative proceedings where the 90 day standard of promptness mandate is ignored should not be considered to justify violation of 42 C.F.R. 431.223 or the clear federal requirement to provide an evidentiary hearing.

Respondent also cites *Brown v. DHHS* (referring to *Tony A. Brown v. DHHS*) in support

⁴ In that case, Mims alleged, among other things, that the State has operated the Medicaid program in violation of the Americans with Disabilities Act (ADA).

of its argument that it may dismiss fair hearing appeals without providing an evidentiary hearing. Docket No. 12-ALJ-08-0067-AP (ALC 2012). But the ruling of this Executive Branch agency in that decision is contradicted by the ruling of the South Carolina Court of Appeals in another “Brown v. DHHS” case, *i.e. Peter Brown v. DHHS*. 393 S.C. 11, 709 S.E.2d 701 (S.C.App. 2011). In that 2011 case, the South Carolina Court of Appeals ordered DHHS to provide Brown an evidentiary hearing meeting the requirements of 42 C.F.R. 431.220(a)(1)-(2) when the DHHS hearing officer dismissed Brown’s “fair hearing” appeal without providing him with an evidentiary hearing. *Id.* In both “Brown” cases, the Administrative Law Court erred as a matter of law in dismissing the appeals in violation of 42 C.F.R. 431.223. In *Peter Brown’s* case, the South Carolina Court of Appeals ruled that “The jurisdiction of any tribunal is determined by the allegations, not by the answer to the questions raised by the allegations.” *Id.* at 704. In those cases, as well as Waddle’s case, DHHS violated federal law by dismissing their fair hearing appeals when (1) the appellant did not request dismissal in writing and (2) did not fail to appear at a scheduled hearing. 42 C.F.R. 431.223.

In *Peter Brown v. DHHS*, instead of complying with Judge Few’s judicial order, the agency again dismissed Brown’s appeal without providing an evidentiary hearing, not only in violation of 42 U.S.C. 1396a(a)(3), but in complete and total disregard of the ruling of the Court of Appeals.

The agency’s actions in this case continue the Respondent’s ongoing and unconstitutional pattern of violating the Separation of Powers provision of the Constitution of South Carolina by delaying judicial review for years through the cycling and recycling of “fair hearing” cases

between DHHS and this Court (that is actually an agency within the Executive Branch of government) - and by disregarding the clear rulings of the Judicial Branch as well as the federal regulations promulgated by CMS which limit the authority of a hearing officer to dismiss a fair hearing appeal.

This Court may take judicial notice of its own Accountability Report, which states that the agency has an "objective" of deciding Medicaid appeals within 180 days. <http://www.scalc.net/pub/pubFY1112ALCAccountabilityReport.pdf> at page 14. But that report also states that only 40% of Medicaid appeals in this agency meet that aspirational standard and that the average number of days a Medicaid case sits pending in the Administrative Law Court is 284 days. This violates federal law, which requires a final administrative decision within 90 days. In actuality, the wait time for Medicaid appellants is much longer in the Administrative Law Court, because each time the case is remanded and either heard or dismissed by the DHHS hearing officer, this Court treats the case as a new one, beginning again at day one.

Other issues.

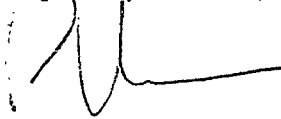
Respondent, without providing Appellant any opportunity to present witnesses, to cross examine the State's witnesses or to present her case in an evidentiary hearing argues that Waddle's complaints should be dismissed without providing an evidentiary hearing. These arguments violate federal law, which requires DHHS to comply with 42 U.S.C. 1396a(a)(3) and to provide an evidentiary hearing.

Conclusion

It is undeniable that Brook has not been provided the equipment her physician ordered or a fair hearing with reasonable promptness and that more than 90 days has passed without a final

administrative decision being rendered which would free Waddle to have her appeal heard by the Judicial Branch of government. *Doe v. Kidd*, 501 F.3d 348 (4th Cir. 2007) and 2011 WL 1058542 (4th Cir. March 24, 2011). This violates the Separation of Powers Doctrine, the ruling of the South Carolina Court of Appeals in *Brown v. DHHS*, as well as federal laws and constitutional due process requirements which require DHHS to provide a hearing. This Court should determine as a matter of law that Respondent is in violation of the Medicaid Act and should order DHHS to pay for the oximeter cable, finding in the process that Waddle is the prevailing party in this appeal. This Court should also award legal fees and costs to Appellant pursuant to South Carolina Code of Laws 15-77-300 (2005). *Layman v. State of South Carolina*, 658 A.E.2d 320, 324, 376 S.C. 434 (S.C. 2008).

Respectfully submitted,



Patricia Logan Harrison
611 Holly Street
Columbia, South Carolina 29205
803 256 2017
plh.cola@att.net

September 25, 2013

THE STATE OF SOUTH CAROLINA
IN THE ADMINISTRATIVE LAW COURT

Appeal from the Division of Appeals and Hearings
South Carolina Department of Health and Human Services

Renee Johnson, Hearing Officer

Docket Number: 13-ALJ-08-0267-AP

BROOK WADDLE,

Appellant,

v.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondent.

RECORD ON APPEAL

Patricia Harrison
611 Holly Street
Columbia, South Carolina 29202
(803) 256-2017
Plh.cola@att.net
ATTORNEY FOR APPELLANT

Shealy Reibold
SCDHHS
Office of General Counsel
P.O. Box 8206
Columbia, South Carolina 29202
(803) 898-2792
(803) 255-8210
reibold@scdhhs.gov
ATTORNEY FOR RESPONDENT

BROOK WADDLE
V.
SOUTH CAROLINA DEPARTMENT OF HEALTH AND
HUMAN SERVICES

ALC DOCKET # 13-ALJ-08-0267-AP

BROOK WADDLE
V.
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DOCKET NO. 13-ALJ-08-0267-AP
SEQUENTIAL INDEX OF PRINCIPAL MATTERS

ITEMS	BEGINNING PAGE #
INDEX	i
I. ORDERS	
ORDER OF DISMISSAL IN THE APPEAL MATTER OF BROOK WADDLE V. SCDHHS	1
II. OTHER MATERIALS AND DOCUMENTS	
EMAIL WITH ENDING DATE OF MARCH 27, 2012, 12:43 PM	3
EMAIL WITH ENDING DATE OF MARCH 27, 2013, 10:17 AM	5
PETITIONER'S SUMMARY OF PRE HEARING CONFERENCE	6
RESPONDENT'S SUMMARY OF PRE HEARING CONFERENCE	9
PRE HEARING CONFERENCE ORDER	10
APPEAL REQUEST	13
OTHER MATERIALS AND DOCUMENTS	15
III. CERTIFICATION OF RECORD	20
IV. CERTIFICATE OF SERVICE	21

ORDER OF DISMISSAL IN THE APPEAL MATTER OF
B. W. (PETITIONER) v. SCDHHS (RESPONDENT)

Appeals' Case # 13-MISC-021 (DME)

Medicaid # 6780499394

Hearing Date: Not held

JURISDICTION

Procedure in this case is governed under the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services (SCDHHS) 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 (Reg. 126-150, et seq.) and the South Carolina Administrative Procedures Act (S.C. Code Ann. 1-23-310, et seq.).

PROCEDURAL HISTORY

The Petitioner is Medicaid eligible. Apria, a provider of durable medical equipment (DME) submitted, on behalf of the Petitioner, a prior authorization request for a piece of medical equipment, specifically an oximeter cable. Kepro, an agent of the Respondent, South Carolina Department of Health and Human Services (SCDHHS) denied the request because no supporting clinical information was submitted with the request. On January 31, 2013, the Petitioner's attorney's appeal was received in the Division of Appeals and Hearings.

ISSUE

The issue is whether the Respondent, through its agent, correctly denied prior authorization for durable medical equipment for the above referenced Medicaid beneficiary. Any issues raised in the proceedings or hearing of this case but not addressed in this Decision are deemed denied.

FINDINGS OF FACT

Having studied the exhibits and closely passed upon their credibility, I make the following Findings of Fact by a preponderance of the evidence:

1. On February 5, 2013, this Hearing Officer issued a Pre Hearing Conference Order to the Petitioner's attorney and the Respondent directing the two parties to participate in a pre-hearing conference. The Petitioner was ordered to provide this Hearing Officer with a statement of her intention to continue with the appeal on or before March 19, 2013, otherwise, this matter would be dismissed.
2. On February 6, 2013, the certified copy of this Pre Hearing Conference Order was delivered to the Petitioner's address.

3. On March 19, 2013, correspondence from the Petitioner's attorney was received via facsimile. However, this correspondence did not address the issues of this appeal and did not state the intention of continuing with this appeal.
4. On March 27, 2013, this Hearing Officer sent an email to the Petitioner's attorney offering an extension until April 2, 2013 to submit the statement of intention.
5. As of the undersigned date, the Petitioner's attorney has not returned a response to this Hearing Officer's Pre Hearing Conference Order.

APPLICABLE LAW

"A Hearing Officer has the authority, among other things, to: direct all procedures, issue interlocutory orders; schedule hearings and conferences; preside at formal proceedings; rule on procedural and evidentiary issues; require the submission of briefs and/or conclusions of law; call witnesses; recess, continue, and conclude any proceedings; dismiss any appeal for failure to comply with the requirements of this subarticle." South Carolina Department of Health and Human Services, Chapter 126, "Administration" R.126-154, §44-6-90, S.C. Code, 1976, as amended.

CONCLUSIONS OF LAW

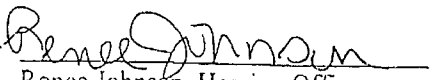
Based upon the above Findings of Fact and Applicable Law, I conclude the following as a matter of law:

In accordance with SCDHHS regulation 126-154, the Petitioner has abandoned the appeal request and this matter is dismissed.

DECISION

This matter is hereby **DISMISSED**.

AND IT IS SO ORDERED.


Renee Johnson, Hearing Officer
Division of Appeals & Hearings

DATED AT COLUMBIA,
South Carolina

April 4, 2013

Renee H Johnson

From: Patricia L Harrison <plh.cola@att.net>
Sent: Wednesday, March 27, 2013 12:43 PM
To: Beth Hutto; Byron Roberts; Renee H Johnson
Cc: kanthony@anthonylaw.com; tippybrook@yahoo.com; Janet Goode; Shealy Reibold
Subject: Re: Brook Waddle Response to Pre-Hearing Conference Order

Ms. Hutto, please advise of the status of the hearing you presided over on October 30 and 31 and our emergency motion for an interim order. When do you expect to issue an order on that hearing? It's been about 270 days since the remand, and at least six years since Brook filed her appeal. DHHS still has paid the mother nothing and has paid nothing toward her speech device.

Thanks.

Trisha Harrison

From: Beth Hutto
Sent: Wednesday, March 27, 2013 9:21 AM
To: Patricia L Harrison ; Byron Roberts ; Renee H Johnson
Cc: kanthony@anthonylaw.com ; tippybrook@yahoo.com ; Janet Goode ; Shealy Reibold
Subject: RE: Brook Waddle Response to Pre-Hearing Conference Order

Ms. Johnson and Ms. Reibold,

I received this message last week but I believe it should have been addressed to you as it concerns a matter in front of Ms. Johnson.

Thank you,

Beth Hutto

From: Patricia L Harrison [<mailto:plh.cola@att.net>]
Sent: Tuesday, March 19, 2013 11:53 PM
To: Beth Hutto; Byron Roberts
Cc: kanthony@anthonylaw.com; tippybrook@yahoo.com; Janet Goode
Subject: Brook Waddle Response to Pre-Hearing Conference Order

Attached is the response to the Pre-Hearing Conference Order in the matter of Brook Waddle, Case No. 13-MISC-021. We would appreciate a status report on our motion for an emergency interlocutory order which was requested in December, 2012.

Thank you.

Trisha Harrison

Confidentiality Note

This message is intended for the use of the person or entity to which it is addressed and may contain

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information, including health information, that is privileged, confidential, and the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED.

If you have received this in error, please notify us immediately and destroy the related message.

Renee H Johnson

From: Renee H Johnson
Sent: Wednesday, March 27, 2013 10:17 AM
To: Beth Hutto; Patricia L Harrison
Cc: kanthony@anthonylaw.com; tippybrook@yahoo.com; Janet Goode; Shealy Reibold; Rick Hepfer; Byron Roberts
Subject: RE: Brook Waddle Response to Pre-Hearing Conference Order

Ms. Harrison,

I believe there is some confusion. Ms. Hutto received the below email and attachment. I believe it was meant to respond to my pre hearing conference order (Appeals Case # 13-MISC-021) but it does not address the issue of my case (denial of prior authorization of an oximeter cable for BW). I will extend the due date until Tuesday, April 2. Please include with your response the documentation of medical necessity for the cable.

Thank you

From: Beth Hutto
Sent: Wednesday, March 27, 2013 9:22 AM
To: Patricia L Harrison; Byron Roberts; Renee H Johnson
Cc: kanthony@anthonylaw.com; tippybrook@yahoo.com; Janet Goode; Shealy Reibold
Subject: RE: Brook Waddle Response to Pre-Hearing Conference Order

Ms. Johnson and Ms. Reibold,

I received this message last week but I believe it should have been addressed to you as it concerns a matter in front of Ms. Johnson.

Thank you,

Beth Hutto

From: Patricia L Harrison [<mailto:plh.cola@att.net>]
Sent: Tuesday, March 19, 2013 11:53 PM
To: Beth Hutto; Byron Roberts
Cc: kanthony@anthonylaw.com; tippybrook@yahoo.com; Janet Goode
Subject: Brook Waddle Response to Pre-Hearing Conference Order

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Thank you.

Trisha Harrison

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

Fair Hearing of Brook Waddle v. DHHS

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

RECEIVED

MAR 22 2013

DHHS 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

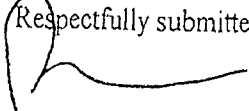
Administrative Procedures Act by failing to promulgate regulations for the operation of Home and Community Based Waiver programs.

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
803 256 2017

March 19, 2013



March 19, 2013

Ms. Renee H. Johnson, Hearing Officer
SC Department of Health and Human Services
Division of Appeals and Hearings
P. O. Box 8206
Columbia, SC 29202-8206

Re: *B.W. v. DHHS*, Case No. 13-MISC-21

Dear Ms. Johnson:

Rick Hepfer and I have been assigned to represent the agency in this matter and have reviewed your Pre-hearing Conference Order dated February 5, 2013. In accordance with your Order, Mr. Hepfer and Ms. Harrison spoke on March 5, 2013 regarding the appeal.

The appeal arose from the denial by KePro of provider Apria's request for prior authorization of an oximeter cable for B.W. The request was denied because Apria did not include any supporting clinical information with the request. KePro gave Apria 48 business hours to submit supporting clinical information and a prescription for the device, but Apria did not submit additional information as requested. The request was denied administratively for failure to supply the necessary information to allow KePro to make a determination.

Petitioner's counsel indicated she had attempted to resolve the issue with KePro and/or Apria but was unsuccessful. Respondent has also made an attempt to resolve this issue by reaching out to the provider and asking Apria to resubmit its request with supporting documentation. At this time, Respondent's overture to Apria is still pending, and the issue remains unresolved.

The parties continue to disagree at this time as to whether the denial was in error. Respondent believes that this is the sole issue between the parties for purposes of this appeal. It is Respondent's understanding that Petitioner intends to raise other issues at the hearing that Respondent believes are irrelevant and outside the scope of the denial of an oximeter cable. Therefore, Respondent defers to Petitioner to allow her to submit to the hearing officer any additional issues she wishes to raise at the hearing.

If there are questions, please do not hesitate to contact me. My direct line is (803) 898-2792.

Sincerely,

Shealy B. Reibold
Assistant General Counsel

SBR/b

cc: Patricia Harrison, Esquire

RECEIVED

MAR 19 2013

SCDHHS APPEALS



February 5, 2013

EMAIL & INTRA-OFFICE MAIL

Maureen Ryan
SCDHHS
1801 Main Street
Columbia, South Carolina 29202-8206

FIRST CLASS & CERTIFIED MAIL

Patricia Harrison, Esquire
611 Holly Street
Columbia, South Carolina 29205

9171 9690 0935 0031 8959 31

RE: Fair Hearing in the Matter of Brook Waddell v. SCDHHS
Appeals' Case #13-MISC-021 (DME)
Recipient # 6780499394

Dear Ms. Ryan and Mrs. Harrison:

Please find enclosed an Order for Pre-hearing Conference in the above referenced matter. Please read the enclosed Order carefully, as you both must file a response as directed by a date certain: **March 19, 2013**. I am including of the appeal request and attachment to Ms. Ryan

If there are any questions, please contact me at 803-898-2661.

Sincerely,

Renee Johnson, Hearing Officer
Division of Appeals and Hearings

Enclosure

cc: Valeria Williams, SCDHHS (via email)
Shealy Reibold, Office of General Counsel SCDHHS (via email)

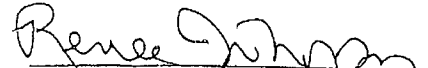
STATE OF SOUTH CAROLINA	)	BEFORE THE DIVISION OF
	)	APPEALS AND HEARINGS
COUNTY OF RICHLAND	)	SOUTH CAROLINA DEPARTMENT OF
	)	HEALTH AND HUMAN SERVICES
B. W.,	)	
	)	
Petitioner,	)	
	)	
-v-	)	PRE HEARING CONFERENCE ORDER
	)	
South Carolina Department of Health	)	Appeals' Case #: 13-MISC-021
and Human Services,	)	(DME)
	)	Medicaid ID # 6780499394
Respondent.	)	
_____	)	

Pursuant to authority granted by SCDHHS Reg. 126-154, the Parties in the above captioned matter are hereby required to coordinate and participate in a telephonic or in-person Pre-hearing Conference, time and place to be mutually agreeable, on or before Tuesday, March 5, 2013 for the purpose of settlement negotiation, narrowing of issues and the examination and full disclosure of relevant and material evidence. The Petitioner's attorney shall contact the SCDHHS Program Manager, Maureen Ryan by phone and/or email at (803) 898-1054/ryanme@scdhhs.gov for the time and place of the conference.

Further, by Tuesday, March 19, 2013, the Respondent is required to submit a summary of issues discussed, whether consensus was reached and any remaining issues. The Respondent's summary should identify, with specificity, any additional information that will be submitted at the hearing or requests that either party anticipates making. Also by Tuesday, March 19, 2013, the Petitioner's attorney is required to submit a statement of intention to continue the appeal process and attend a Fair Hearing. Upon receipt of the summary and the statement of intention, a hearing will be scheduled depending on the Hearing Officer's calendar. SCDHHS evidentiary Fair hearings are in person and are not be conducted telephonically.

Pursuant to the South Carolina Department of Health and Human Services Regulation §126-154, failure to comply with the terms of this order will constitute grounds for dismissal against the non-complying party, or subject the non-complying party to a limitation of proffered testimony and/or evidence at the hearing.

AND IT IS SO ORDERED.


Renee Johnson, Hearing Officer
Division of Appeals and Hearings

DATED AT COLUMBIA,
South Carolina

February 5, 2013

Robert French

From: Beth Hutto
Sent: Wednesday, January 30, 2013 11:20 PM
To: Robert French
Subject: FW: BW v. DHHS
Attachments: photo.JPG

Importance: High

FYI:

-----Original Message-----

From: Patricia L Harrison [mailto:plh.coia@att.net]
Sent: Wednesday, January 30, 2013 11:17 PM
To: Beth Hutto; Byron Roberts; Rick Hepfer
Cc: kanthony@anthonylaw.com
Subject: BW v. DHHS
Importance: High



Ms. Hutto and Gentlemen, Brook faxed me this afternoon the attached denial of replacement DME supplies for her tracheostomy she just received from Kepro. I am filing an appeal and requesting that supplies for and treatment of her tracheostomy be continued during this appeal. Brook is still not receiving the hours she was receiving when she filed the appeal. Her mother has been paid nothing for the services she has provided to Brook, despite Judge McLeod ordering DHHS to pay for past services nearly six months ago.

We are providing the most recent denial as additional evidence that DHHS has improperly reduced and denied services in violation of the ADA and the Medicaid Act. We are requesting that the record be supplemented with this latest denial.

Brook nearly died when a tracheostomy tube was improperly inserted at MUSC, leading to her having the surgery in New York. DHHS has extensive documentation of her need for tracheostomy supplies and what happened to her when the wrong tube was inserted. As the nurse testified, Brook has to be suctioned throughout the day and not having the prescribed supplies could be life threatening to her.

Because Brook does not have an operational speech device, I have been unable to speak with her about the denial, but we are requesting that these replacement tracheostomy supplies continue to be provided immediately. I would appreciate your confirmation, Byron, that Brook's tracheostomy supplies will be continued during this appeal.

I will send the second page of this denial in an email to follow. Thank you, Byron, for your immediate attention to this potentially life threatening error.

Trisha Harrison

NOTICE OF DENIAL

BROOK WADDLE

142 ROYAL BURGESS DR
CAMPOBELLO, SC 29322

Date: 01/09/2013

RG General Information

Medicaid ID: 8780499394
Member Name: BROOK WADDLE
Date of Birth: 1/14/1988
Case ID: 130040057
Authorization Number:

KePRO is under contract with the South Carolina Department of Health and Human Services/Medicaid to perform Prior Authorization review services for Medicaid members.

This letter is being sent to let you know that the request we received from APRIA HEALTHCARE INC for your service has been denied. Based on our review and administrative requirements, we must deny the request for coverage.

Why we are Denying

Provider submitted no clinical information supporting request and prescription when requested to do so.

Your doctor has received a copy of this denial and can discuss with you the reason for the denial. We will also be happy to send you a copy of the criteria we used for the review by calling 1(855)326-5213.

Code	Service Description	Req Units	Apprv Units	Denied Units	FREQ	Start Date	End Date	Authr Number
A0300	DME SUPPLY OR ACCESSORY NOS	1	0	1		01/07/2013	01/07/2013	

Created: 01/26/2012

Approved: 03/01/2012

South Carolina Department of Health and Human Services
Division of Appeals and Hearings

CERTIFICATE OF MAILING

Brook Waddle, 13-MISC-021
Renee H Johnson, Hearing Officer

I hereby certify that I have this day served the Attached Order along with Rule 71 of the Rules of Procedure for the Administrative Law Court upon the parties of record in this proceeding set forth below by mailing a copy via certified mail, by inter-agency courier, or by electronic scanning with electronic mail delivery notice.

ATTORNEY REPRESENTATIVE

Patricia Harrison Esquire,
611 Holly Street
Columbia, SC 29205

9171 9690 0935 0031 7545 35

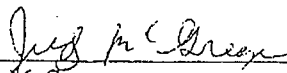
(via: certified mail)

Office of General Counsel, SCDHHS
Richard Hepfer, Esquire, Deputy General Counsel, SCDHHS
Valeria Williams, Division Director, DME, Pharmacy and Physicians Services, SCDHHS
Maureen Ryan, Office of Physician, Pharmacy, and Enhanced Care, SCDHHS
Shealy Reibold, Esquire, General Counsel, SCDHHS

(via: electronic mail delivery notice of electronic scanning)

DATED this 8 day of April, 2013
Columbia, SC




Judy McGregor
Appeals and Hearings, SCDHHS



April 4, 2013

CERTIFIED MAIL

Patricia Harrison Esquire
611 Holly Street
Columbia SC 29205

RE: Order of Dismissal in the Appeal Matter of Brook Waddle v. SCDHHS
Appeals' Case # 13-MISC-021 (DME)
Medicaid # 6780499394

Dear Ms. Harrison Esquire:

The Order of Dismissal in the referenced appeal matter is set forth in the enclosure.

Any party has the right to petition for further review of this Decision/Order, 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 thirty (30) days of receipt of this Decision/Order.** A copy of the Notice of Appeal should be provided to the S. C. Department of Health and Human Services' (SCDHHS) Office of General Counsel. The Notice of Appeal must be submitted in accordance with Rule 33 of the Rules of Procedure for the S.C. Administrative Law Court, which establishes specific requirements for the contents of a Notice of Appeal. Rule 35 directs that the party filing the Notice of Appeal is responsible for ordering the transcript and filing a copy of the request with the Notice of Appeal. The **original** request for transcript should be directed to the SCDHHS' Division of Appeals at the address below. **In accordance with the ALC rules, the cost of producing the transcript will be the responsibility of the party requesting appellate review.** For a copy of the ALC rules, you may contact the Administrative Law Court at (803) 734-0550.

Also, please see the enclosed Rule 71 of the Rules of Procedure for the ALC, which sets forth the required filing fee for an appeal.

Sincerely,

Robert French, Chief Hearing Officer
Division of Appeals and Hearings

RF/jpm
Enclosures (2)

Patricia Harrison Esquire

April 4, 2013

Page Two

cc: Office of General Counsel, SCDHHS
Richard Hepfer, Esquire, Deputy General Counsel, SCDHHS
Valeria Williams, Division Director, DME, Pharmacy and Physicians Services, SCDHHS
Maureen Ryan, Office of Physician, Pharmacy, and Enhanced Care, SCDHHS
Shealy Reibold, Esquire, General Counsel, SCDHHS

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ACKNOWLEDGMENT RECEIPT

Please sign, date and return to the Division of Appeals and Hearings

Maureen Ryan, SCDHHS
SENT TO

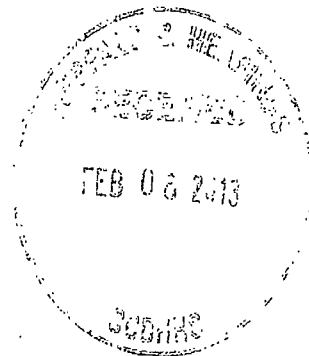
TYPE OF DOCUMENT: (Pre Hearing Conference: 13-MISC-006)
Brooke Waddle

PERSON RECEIVING DOCUMENT:

DATE RECEIVED:

Maureen Ryan
2/5/13

RHJ 2/5/13



STATE OF SOUTH CAROLINA)

COUNTY OF RICHLAND)

CERTIFICATION

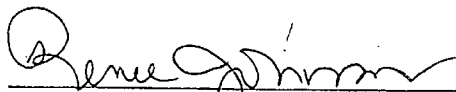
This is to certify that I, Renee Johnson, Notary Public for the State of South Carolina and Hearing Officer for the South Carolina Department of Health and Human Services, did review the case record for Brook Waddle v. South Carolina Department of Health and Human Services (SCDHHS Appeals' Case # 13-MISC-021). The enclosed is the complete record to the best of my knowledge and belief.

There was no hearing; therefore, there was no transcript.

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MAY 20 2015

SC Court of Appeals



Renee Johnson, Hearing Officer
Notary Public, State of South Carolina
My Commission Expires: December 6, 2020.

DATED AT COLUMBIA
South Carolina

June 27, 2013

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

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MAY 20 2015

SC Court of Appeals

BROOK WADDLE,

Appellant,

v.

SOUTH CAROLINA DEPARTMENT OF,
HEALTH AND HUMAN SERVICES,

Respondent.

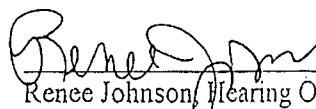
Docket Number
13-ALJ-08-0267-AP

CERTIFICATE OF SERVICE BY CERTIFIED MAIL TO PATRICIA HARRISON,
ESQUIRE, AND INTRA-AGENCY MAIL TO SHEALY REIBOLD, SCDHHS
GENERAL COUNSEL

I HEREBY CERTIFY that a true and exact copy of the South Carolina Department of Health and Human Services' Record on Appeal in the above referenced matter has been forwarded to Patricia Harrison and Shealy Reibold this 27 of June, 2013, by Certified Mail and Intra-Agency Mail, addressed as set forth:

Patricia Harrison
611 Holly Street
Columbia, South Carolina 29202
(803) 256-2017
Plh.cola@att.net
ATTORNEY FOR APPELLANT

Shealy Reibold
SCDHHS
Office of General Counsel
P.O. Box 8206
Columbia, South Carolina 29202
(803) 898-2792
(803) 255-8210
reibold@scdhhs.gov
ATTORNEY FOR RESPONDENT


Renee Johnson, Hearing Officer
SCDHHS
Division of Appeals and Hearings
Post Office Box 8206
Columbia, SC 29202
(803) 898-2661
Fax (803) 255-8206
johnsrh@scdhhs.gov

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SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA

Administrative Law Court

Ralph K. Anderson, III, Chief Administrative Law Judge

Appellate Case No. 2013-002415

Brook Waddle, ... Appellant,

v.

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

CERTIFICATE OF COMPLIANCE

Patricia Logan Harrison certifies that the *Brief of Appellant* and the *Reply Brief of Appellant* in the above captioned case complies with Rule 211(b).

May 18, 2015



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

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MAY 20 2015

SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA

Administrative Law Court

Ralph K. Anderson, III, Chief Administrative Law Judge

Appellate Case No. 2013-002415

Brook Waddle, ... Appellant,

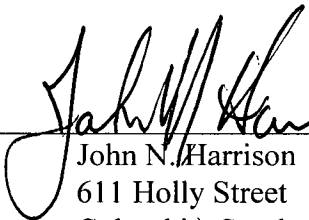
v.

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

CERTIFICATE OF SERVICE

John N. Harrison certifies that he has served the *Brief of Appellant* and the *Reply Brief of Appellant* in the above captioned case by United States Mail to the following on May 18, 2015:

Damon C. Wlodarczyk, Esq.
Riley Pope & Laney, LLC
PO Box 11412
Columbia, SC 29211



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