

**STATE OF WEST VIRGINIA**

 **DEPARTMENT OF HEALTH AND HUMAN RESOURCES**

 **BUREAU FOR MEDICAL SERVICES**

 **Commissioner’s Office**

**Cynthia E. Beane**

**Commissioner**

**Bill J. Crouch**

**Cabinet Secretary**

 350 Capitol Street, Room 251

 Charleston, West Virginia 25301-3712

 Telephone: (304) 558-1700 Fax: (304) 558-1451

Date:

Name:

Address:

Medicaid WV CSED Waiver Program

[ ]  Your Initial Waiver Application is hereby denied.

Your application was denied because:

[ ]  An eligible diagnosis is not supported by T-scores greater than 60 in 2 or more of the Clinical Scales on the BASC.

[ ]  Functional impairment is not substantiated by a Youth Total Score of 90 or above on the CAFAS/PECFAS.

[ ]  Functional impairment is not substantiated by at least one Subscale of 30 on the CAFAS/PECFAS.

Reviewer(s) relied on the following facts:

**SECOND MEDICAL EVALUATION:** You have the right to a **second psychological evaluation** at the department’s expense if the decision was based on medical reasons; the second psychological evaluation must be submitted within 60 calendar days of this letter. You have the right of access to your file and copies free of charge.

**FAIR HEARING:** If you do not agree with the decision, you may ask for a **Fair Hearing** and/or a Pre-Hearing Conference within 90 days of the date of this letter. A form to ask for a Fair Hearing and/or a Pre-Hearing Conference is also enclosed. Within 90 days, you must complete this form and submit it to the address on the Hearing Request form. If this action is termination of your benefit, your service may continue until your hearing is held and a final decision is made by the hearing officer; but you must ask for a Hearing/Pre-Hearing Conference within 13 days of this notice in order to receive continued benefits. The following organizations provide **free legal services** to eligible persons: Disability Rights of West Virginia, 1207 Quarrier Street, Charleston, WV 25301; 1-800-950-5250 and Legal Aid of WV, 922 Quarrier Street, 4th Floor, Charleston, WV 25301; 1-800-642-8279; Mountain State Justice, 1031 Quarrier Street, Suite 200, Charleston, WV 25301 at 1-800-319-7132. The Department will assist in arranging transportation if needed.

If your initial application for Waiver was denied, please proceed to page 2.

Information on pages 4, 5 and 6 apply to all who receive this letter.

The policy upon which the decision is based: WV CSED Waiver Manual Chapter 502, 502.14.2, 502.15.

**Denial After Initial Assessment**

**Option #1: Asking for a second medical examination with a psychologist**

You have received notice that you have been denied for the CSED Waiver program. Your options include the following: You may ask for a 2nd medical examination completed at DHHR’s expense, or you may ask for a Medicaid Fair Hearing.

**If you have already had a 2nd medical exam that resulted in continued denial from the CSED Waiver program, this option is not available**. **You may ask for a Medicaid Fair Hearing (See Option 2).**

A 2nd medical examination must be completed within sixty (60) days of the date you received your denial letter. The evaluation may take one (1) to three (3) hours to complete. If you choose this option, a Psychologist who works with DHHR will complete a full psychological evaluation. This evaluation will include an interview with you and/or your representative. You may also be asked to have the following available for the evaluation:

* + Someone who knows your history, mental health history and daily functioning;
	+ Reports of previous psychological evaluations or private assessments completed such as psychiatric evaluations, treatment summaries, medical records and psychological assessments;
	+ Previous scores on the Child and Adolescent Functional Assessment Scale (CAFAS) or the Preschool and Early Childhood Functionality Scale (PECFAS);
	+ Discharge summaries conducted in previous psychological placements;
	+ School records, reports of psycho-educational testing conducted by the school system, the most current IEP;
	+ A list of medications prescribed to you; and
	+ Any other documentation which may assist the psychologist in conducting the evaluation.

**To ask for a second medical examination**, please complete the “Second Medical Examination IPN Response Form”form attached **OR** write “I want a second medical exam” on any open space on the attached Request for Hearing form. You may also call KEPRO directly at 1-844-304-7107 for assistance.

**Option #2: Asking for a Medicaid Fair Hearing**

A request for Medicaid Fair Hearing must be submitted to the Board of Review (BOR) within ninety (90) days of receiving your denial letter. If you have already been receiving services and submit the form within fourteen (14) days, you may continue your services until the Medicaid Fair Hearing. This hearing is a formal process to appeal your denial from the CSED Waiver program. A Hearing Officer with the BOR will hear your case and why you believe you are eligible for the program. The Hearing Officer will review all information to make sure policy was followed. Other people will also participate in the hearing such as the Psychologist who reviewed your information and determined you are not eligible for the program. You may have others attend to help support your case.

After the hearing, the Hearing Officer will let you know by letter if they agree or disagree with the decision to deny you from the program. If they agree (uphold DHHR’s decision), you will not be able to begin or continue CSED Waiver services. If they disagree (overturn DHHR’s decision), you will be able to begin to receive services (if you are an applicant and if a slot is available) or be placed on the Managed Enrollment List (if you are an applicant and a slot is available), or remain active (if you were already receiving CSED Waiver services).

**To ask for a Medicaid Fair Hearing,** complete the Request for Hearing Form and send it to:

Board of Review

Building 6, Capitol Complex

Charleston, WV 25305

If you have questions, please contact KEPRO at 1-844-304-7107.

**Determination Process, Rights, and Due Process Information:**

**502.14.1 Initial Eligibility Determination Process:**

Each new applicant must follow the eligibility process listed below for medical eligibility. An applicant may obtain an Application Form (WV-BMS-CSED-1) from the MCO (Aetna), CSEDW providers, local/county DHHR Offices, the ASO (KEPRO) or via the WV BMS CSEDW website.

Completed applications must be submitted to the ASO (information on how to submit is located on the application). Upon receipt of the WV-BMS-CSED-1, the ASO date and time stamps the application.

The ASO contacts the applicant within three business days upon receipt of the WV-BMS-CSED-1 and provides a list of Independent Psychologists (IP) in the Independent Psychologist Network (IPN) trained by the Medical Eligibility Contracted Agent (MECA) that are available within the applicant’s geographical area. The applicant chooses a psychologist from the IPN and contacts the IP to schedule the appointment within 14 calendar days and submits and IPN Response Form to the ASO identifying the selected IP.

Psychologists in the IPN are identified and placed on the IPN list following documented training by the MECA. The IP is responsible for completing an IPE and uploading it to the required internet site within 45 calendar days of the receipt date of the IPN Response Form by the ASO. The evaluation includes assessments which support the diagnostic impressions offered and relevant measures of functioning. The IPE is utilized by the MECA to make a medical eligibility determination.

The MECA makes a final medical eligibility determination within 30 calendar days of receipt of the completed IPE. A written decision is mailed to the applicant and/or their parent/legal representative by the ASO. If an applicant is approved for medical eligibility by the MECA and a funded CSEDW slot is available, then the applicant is enrolled into the CSEDW program. If a slot is not available, then the applicant will be placed on a managed enrollment list until a funded slot allocation is available.

If an applicant is determined to not meet medical eligibility criteria by the MECA, a written Notice of Decision, a Request for a Medicaid Fair Hearing form, and a copy of the IPE is mailed by certified mail by the ASO to the applicant or the parent/legal representative. This denial of medical eligibility may be appealed by the applicant or the parent/legal representative through the Medicaid Fair Hearing process by submitting the request for Medicaid Fair Hearing form to the Board of Review within 90 calendar days of receipt of the Notice of Decision. The Notice of Decision letter also allows the applicant or the parent/legal representative to request a second medical evaluation.

If a second medical evaluation is requested, then it must be completed within 60 calendar days by a different member of the IPN. If an applicant is determined to be medically eligible and a slot is available, then the applicant is enrolled into the CSEDW program. If a slot is not available, then the applicant will be placed on a managed enrollment list until a funded slot is available.

If the applicant is again determined by the MECA to not meet medical eligibility criteria following the second medical evaluation, then the applicant or their parent/legal representative of the applicant will receive a Notice of Decision, a Request for Medicaid Fair Hearing form and a copy of the second IPE by certified mail by the ASO. This second denial of medical eligibility may be appealed through the Medicaid Fair Hearing process by submitting the Request for Medicaid Fair Hearing form to the Board of Review within 90 calendar days of receipt of the Notice of Decision and a Medicaid Fair Hearing will be scheduled.

The applicant or parent/legal representative may request a pre-hearing conference at any time prior to the Medicaid Fair Hearing. At the pre-hearing conference, the applicant and/or the parent/legal representative and a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for denial.

The applicant shall have the right to access their IPE used by the MECA in making the eligibility decision and copies shall be provided free of charge by BMS.

If the denial of initial medical eligibility is reversed by the Hearing Officer, the applicant will be placed on the managed enrollment list based on the date of the Hearing Officer’s decision. When a slot is available, the applicant will be enrolled in the program.

The applicant’s right to a medical eligibility determination within 90 calendar days may be forfeited if the applicant fails to schedule and keep a timely appointment or does not submit follow-up information needed to complete the IPE to the IP within a reasonable timeframe specified by the IP. Examples of follow-up documentation requested by the IP may include, but may not be limited to:

* Individualized Education Program (IEP) plan for school aged children;
* Psychiatric and Psychological Evaluations;
* Outpatient therapy notes and progress notes;
* Records from Inpatient Psychiatric Hospitalizations, Partial Hospitalizations, or Residential Placements; and
* Any other additional documentation deemed necessary by the IP to complete the IPE.

**Any applicant denied medical eligibility may re-apply to the CSED Waiver Program at any time.** **You have the right to apply without delay. All persons who apply are entitled to an eligibility determination within 90 days of the date of application.**

**513.6.2 Initial Medical Eligibility**

To be medically eligible, the applicant must require the level of care and services provided within a Psychiatric Residential Treatment Facility (PRTF) as evidenced by required evaluations and other information requested by the IP or the MECA and corroborated by narrative descriptions of functioning and reported history.

To be eligible for CSEDW, an applicant must have:

* Eligible Diagnosis;
* Functional Impairment; and
* Require PRTF Level of Care.

**502.14.2.2 Diagnosis**

An eligible diagnosis is defined as a diagnosable mental, behavioral, or emotional disorder that meets the current DSM diagnostic criteria. Excluded diagnosis may include, but are not limited to, substance use/abuse disorders if primary, intellectual, or developmental disabilities, organic brain syndromes, and social/emotional conditions (V codes per DSM or Z codes per the ICD-10-CM). Additionally, ratings on the most current BASC must reflect T-scores greater than 60 in two or more of the clinical subscales. The potentially eligible diagnosis must be supported by additional documentation provided (i.e., previous psychological evaluations, IEP, facility records, etc.).

The applicant must demonstrate an impairment in functioning that is due to an eligible diagnosis.

**502.14.2.3 Functionality**

The applicant must have a substantial impairment in functioning that is defined as a Youth Total score of 90 or above on the PECFAS/CAFAS. The applicant must demonstrate an ability to engage in activities of daily living but lack adequate emotional or behavioral stability to meet the demands of daily living. The CAFAS/PECFAS must reflect elevated scores as noted above. The presence of substantial impairment must be supported not only by relevant test scores, but also the narrative descriptions contained in the documentation submitted for review and other relevant information (i.e., previous psychological testing, the IEP, treatment records, discharge summaries, etc.).

Within the total score of 90, one or more of the following PECFAS/CAFAS subscales must be a score of 30:

* School/day care/work role performance
* Home role performance
* Community role performance
* Behavior toward others
* Moods/emotions
* Self-harmful behavior
* Substance use (CAFAS only)
* Thinking/communication

**502.14.2.4 PRTF Level of Care**

The applicant must require a PRTF level of care and specifically has either resided in a PRTF within the past six months, or through evaluations it is determined that there is a reasonable indication that the applicant is in imminent (one month or less) danger of being placed in a PRTF.

**DUE PROCESS RIGHTS:**

A) If an application is denied, you will receive a “Notice of Decision” letter, “Second Medical Examination IPN Response Form,” and “Request for Hearing” form (Please see attached). You may appeal the decision through the fair hearing process.

B) If WV CSED Waiver services are terminated or reduced, you will receive a “Notice of Decision” letter and “Request for Hearing” form. You may appeal the decision through the fair hearing process. If the services are terminated, they may continue until the hearing is held, but the request for hearing or pre-hearing conference must be made within 14 days of the date of notice.

C) If the WV CSED Waiver services are delayed; you may use the attached “Request for Hearing” form to request a hearing.

D) You shall be afforded 90 days to request a hearing. Any applicant, recipient or authorized representative may request a hearing and must do so either by any written request or by using the attached “Request for Hearing” form.

E) Those who request a hearing shall be entitled to a final administrative action within 90 days of the date of the request for hearing unless you waive the right to a final administrative action within 90 days.

F) You shall have a right to a Second Independent Psychological Evaluation by the Independent Psychological Network at BMS’s expense. If you want a Second Medical Evaluation, you must complete the accompanying Second Medical Examination IPN Response Form **OR** contact KEPRO at 866-473-2354 within **14 calendar days** to request a referral for an Independent Psychological Evaluation, which must be completed within 60 days upon receipt of this letter.

G) You shall have the right to access your file and copies free of charge.

H) The Department will assist in arranging transportation to the hearing, if needed.

**If you have questions, you can also contact:**

**West Virginia Advocates at (800) 950-5250;**

**Legal Aid of West Virginia at (866) 255-4370; or**

**Mountain State Justice at (800) 319-7132.**

**Second Medical Examination: Independent Psychologist Network (IPN) Response Form**

(Your Second Medical Exam request is not considered complete until KEPRO receives this form)

**If you have any questions, please contact KEPRO at Phone Number 1-844-304-7107**

|  |
| --- |
| **Applicant Information** |
| First Name, MI, Last Name |  | Date of Birth |  |
| Mailing Address |  |
| Phone Number |  | Social Security Number |  |
| Medicaid Number  |  | Gender | [ ]  Male [ ] Female |
| Email Address (if applicable) |  | County of Residence |  |
| **Legal Representative Information** |
|  [ ] N/A If member is own representative  |  [ ] Parent of a child under the age of 18  |  [ ] Legal Guardian  |  [ ] WVDHHR Guardian  |
| First Name, MI, Last Name |  | Phone Number |  |
| Mailing Address |  |
| Email Address (if applicable) |  |
| **Independent Psychologist Selected**  |
| * I choose \_\_\_\_\_to complete my **2nd** Independent Psychological Evaluation (IPE) so that medical eligibility can be determined for the WV CSED Waiver Program.
* I consent for the release of all medical records, psychiatric records, substance abuse records, previous evaluations, academic records, social and developmental history for the purpose of an Independent Psychological Evaluation for CSED Waiver Services to the above-named psychologist, BMS and all its contracted agents.

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| Signature Date |
| **Please mail, fax or email this completed and signed form within 14 days to KEPRO** |
| **Mail**   | KEPROAttn: CSED Waiver - IPN Response Form1007 Bullitt Street, Suite 200Charleston, WV 25301 |
| **Fax** | 1-866-473-2354Attn: CSED Waiver – IPN Response Form |
| **E-mail** | wvcsedw@kepro.com |
| UMC Use Only | Completed Application Date:  |

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

BUREAU FOR MEDICAL SERIVES (MEDICAID)

REQUEST FOR HEARING

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RECIPIENT ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE NUMBER WHERE YOU CAN BE REACHED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am requesting a fair hearing for the following reasons:

 (PRINT NAME)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(PLEASE LIST SERVICE THAT WAS DENIED. BE AS SPECIFIC AS POSSIBLE. USE THEOTHER SIDE OF FORM, IF NECESSARY, FOR MORE SPACE)

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

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

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

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

 ( ) Participate in the hearing by telephone conference

 ( ) Participate in the hearing in person at local office

 ( ) Participate I the hearing at Bureau for Medical Services office in Charleston

 (With reimbursement for travel mileage, if requested)

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ( ) I need special accommodation for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ( ) I need help with transportation reimbursement for the hearing

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

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

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**Return this request to: Bureau for Medical Services**

 **Appeals Section**

 **350 Capitol Street, Room 251**

 **Charleston, WV 25301-370**

A staff member will try to contact you by telephone within approximately five (5) days of receipt of this form. After the telephone contact, you will then be notified in writing of the hearing date and time within thirty (30) days.

**CSED Waiver Program**

 **Revised March 2021**