

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TEXAS
TYLER DIVISION

ALBERTO N., ET AL.,

Plaintiffs,

vs.

DON A. GILBERT, ET AL.,

Defendants.

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CIVIL ACTION NO. 6:99CV459

PARTIAL SETTLEMENT AGREEMENT

I. Parties to the Agreement

1. The parties to this Agreement are the Named Plaintiffs in *Alberto N., et al. v. Don A. Gilbert, et al.*, Civil Action No. 6:99CV459, United States District Court, Eastern District of Texas, Tyler Division: Alberto N., by his parents and next friends, Mr. and Mrs. N.; Alice F., by her next friend, Ms. K.; Keyaira R.-D., by her parent and next friend, Ms. D.; Kaitlyn C., by her parent and next friend, Ms. C.; Aaron D., by his parent and next friend, Ms. D.; Andrew M., by his parent and next friend, Ms. M.; Evan W., by his parents and next friends, Mr. and Mrs. W.; and Chelsea C., by her parent and next friend, Ms. C.; and the Named Defendants, Don A. Gilbert, in his official capacity as Commissioner of the Texas Health and Human Services Commission, Dr. Charles Bell, in his official capacity as the Deputy Commissioner of the Texas Department of Health, and James R. Hine, in his official capacity as the Commissioner of the Texas Department of Human Services.

II. General Provisions

2. It is expressly understood and agreed that all terms of this document are contractual and not merely recitals. The parties to this Agreement intend that this written document will incorporate the full terms and conditions of their agreement. It is also understood that the titles for each section of the document and all exhibits are part of the Agreement.

3. The parties acknowledge that this Agreement does not alter federal law and that such law and the terms of this Agreement will govern in any future action under this Agreement.

4. This Agreement applies to persons under the age of 21 years who are eligible to receive Early and Periodic Screening, Diagnosis, and Treatment (Texas Health Steps) benefits under the Texas Medical Assistance Program, established under Chapter 32, Texas Human Resources Code.

5. This Agreement is limited in scope to the issues raised in Plaintiffs' First Amended Complaint, filed in Civil Action No. 6:99CV459, and as described in paragraphs 51 and 52.

6. This Agreement is subject to the approval of the Attorney General, the Governor, and the Comptroller of the State of Texas. Defendants will make a good faith effort to obtain all necessary approvals by October 15, 2001.

7. To the extent that any provision of this Agreement is held to be invalid or unenforceable, such provision shall be severed from the remainder of the Agreement and the Agreement shall be construed as if the invalid or unenforceable provision did not exist.

III. Definitions

8. “Agency” means the Health and Human Services Commission and, when appropriate, the agency operating the relevant part of the Texas Medical Assistance Program.
9. “Contractor” means the health insuring organization, as that term is defined in 42 C.F.R. § 434.2, for the Texas Medical Assistance Program.
10. “Federal financial participation” means the federal government’s share of a state’s expenditures under the Medicaid program.
11. “Medicaid” means the Texas Medical Assistance Program established under the provisions of Chapter 32, Texas Human Resources Code, and subject to the requirements of Title XIX of the Social Security Act and its regulations.
12. “Notice” means a letter provided by the Agency to a Medicaid beneficiary under the age of 21 informing the beneficiary of any reduction, denial, or termination of a requested service, as described in 42 C.F.R. §§ 431.206 and 431.210.
13. “Policy” means all terms, criteria, guidelines, and standards that inform Agency action.
14. “Therapy” means occupational therapy, physical therapy, and services for individuals with speech, hearing and language disorders, as those terms are defined in 42 C.F.R. § 440.110.

IV. Resolution as to Certain Claims

A. Notice

15. Specific notice must be provided upon a determination by the Agency reducing, denying, or terminating a requested Medicaid service. The basis for such a determination will be limited to either not medically necessary or because federal financial participation is not available.
16. The notice informing the Medicaid beneficiary of a reduction, denial, or termination of a requested service because there is no federal financial participation for the requested service shall:
 - (a) state that this is the basis;
 - (b) contain an explanation of the basis for the Agency’s decision, applying the state or federal law to the individual’s particular request; and
 - (c) cite the particular federal law that prohibits federal financial participation for the requested service.
17. All notices required under this Agreement pursuant to paragraph 16 must contain—
 - (a) The dates, type, and amount of service requested;
 - (b) A statement of what action the Agency intends to take (i.e., a reduction, denial, or termination of services);
 - (c) The basis for the intended action;

- (d) An explanation of the basis for the Agency's decision, applying the state and/or federal law to the individual's particular request;
- (e) A cite to the particular federal law that prohibits federal financial participation for the requested service;
- (f) A toll free number for the individual's use in seeking additional information regarding the intended action, for requesting help understanding the notice, and for requesting a fair hearing;
- (g) Information about accessing medical case management; and,
- (h) An explanation of --
 - (1) The individual's right to a fair hearing;
 - (2) The number of days and date by which the fair hearing must be requested;
 - (3) The individual's right to represent himself or herself, or use legal counsel, a relative, friend, or other spokesman;
 - (4) The right to either a written, telephonic, or in-person hearing;
 - (5) The right to examine, at a reasonable time before the date of the hearing, the contents of the case file and any and all documents to be used by the Agency at the hearing; and,
 - (6) The circumstances under which services will be continued if a hearing is requested.

18. The notice informing the Medicaid beneficiary of a reduction, denial, or termination of a requested service, based on a determination that the requested service is not medically necessary, shall (a) state that this is the basis; (b) contain an explanation of the medical basis for the Agency's decision, applying the Agency's policy or the accepted standards of medical practice to the individual's particular medical circumstances; and (c) cite the particular state and federal law that supports, or the change in state or federal law that requires, the intended action.

19. All notices required under this Agreement pursuant to paragraph 18 must contain--
- (a) The dates, type, and amount of service requested;
 - (b) A statement of what action the Agency intends to take (i.e., a reduction, denial, or termination of services);
 - (c) The basis for the intended action;
 - (d) An explanation of the medical basis for the Agency's decision, applying the Agency's policy or the accepted standards of medical practice to the individual's particular medical circumstances;
 - (e) A cite to the particular state and federal law that supports, or the change in state or federal law that requires, the intended action;
 - (f) A toll free number for the individual's use in seeking additional information regarding the intended action, for requesting help understanding the notice, and for requesting a fair hearing;
 - (g) Information about accessing medical case management; and,
 - (h) An explanation of --

- (1) The individual's right to a fair hearing;
- (2) The number of days and date by which the fair hearing must be requested;
- (3) The individual's right to represent himself or herself, or use legal counsel, a relative, friend, or other spokesman;
- (4) The right to either a written, telephonic, or in-person hearing;
- (5) The right to either examine, at a reasonable time before the date of the hearing, the contents of the case file and any and all documents to be used by the Agency at the hearing; and
- (6) The circumstances under which services will be continued if a hearing is requested.

20. When a request for prior authorization is submitted to the Agency or its contractor with incomplete specific documentation/information: the Agency or its contractor will return the request to the Medicaid provider with a letter describing the documentation that needs to be submitted, or when possible, the Agency or its contractor will contact the Medicaid provider by telephone and obtain the information necessary to complete the prior authorization process. If the documentation/information is not provided within sixteen (16) business hours of its request to the Medicaid provider, a letter will be sent to the Medicaid beneficiary explaining that the request cannot be acted upon until the documentation/information is provided, along with a copy of the letter sent to the Medicaid provider describing the documentation/information that needs to be submitted. If the documentation/information is not provided to the Agency or its contractor within seven days (7) of its letter to the Medicaid beneficiary, a notice will be sent to the Medicaid beneficiary informing the beneficiary of its denial of the requested service due to the incomplete documentation/information, and providing the beneficiary an opportunity to request a fair hearing. Notwithstanding the above, the Agency shall require its contractor to modify these procedures as necessary to improve the prior authorization process. The Agency shall notify Plaintiffs' counsel thirty (30) days prior to the implementation of any such changes.

21. Notices must substantially conform to the sample notices attached as Exhibit A.

22. All notices required under this Agreement must be written at a sixth grade reading level with the exception of citations, medical terms, policy, or law.

23. Within six (6) months of the effective date of this Agreement, the Agency shall require its contractor to implement the terms of paragraphs 15 through 22.

B. Fair Hearings

24. The Agency's fair 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 42 C.F.R. §§ 431.200-250.

25. Hearing decisions must be based exclusively on evidence introduced and received at the hearing and must meet the standards specified in 42 C.F.R. § 431.244. This requirement will be reduced to writing and will be part of the training and guidance materials provided to all Agency hearing officers.

26. Because fair hearings must be based exclusively on evidence introduced and received into evidence at the hearing, hearing officers are prohibited from engaging in ex parte communications relating to matters to be adjudicated. This prohibition will be reduced to writing and will be part of the training and guidance materials provided to all Agency hearing officers.

27. If the fair hearing decision sustains the Agency action reducing, denying, or terminating a requested service on the basis that there is no federal financial participation, the decision must contain an explanation of the basis for the hearing officer's decision, applying the state and federal law to the individual's particular request.

28. If the fair hearing decision sustains the Agency action reducing, denying, or terminating a requested service on the basis that the service is not medically necessary, the decision must contain an explanation of the medical basis for the hearing officer's decision, applying the Agency's policy or the accepted standards of medical practice to the individual's particular medical circumstances.

29. All hearing decisions must substantially conform to the sample hearing decision attached as Exhibit B.

30. Within thirty (30) days of the date of the fair hearing decision, the Agency will redact all confidential information from the decision and make it available to the public.

C. Therapy

31. The parties agree that no limitations exist for the provision of medically necessary physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, for which federal financial participation is available. The Agency shall approve medically necessary physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, except where federal financial participation is not available.

32. The Agency shall provide medically necessary physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders if there is or will be progress made towards a goal, as supported by documentation from the prescribing physician and the treating therapist. Therapy goals include improving function, maintaining function, or slowing the deterioration of function.

33. The Agency will revise the Medicaid Provider Procedures Manual to conform with the policies described in paragraphs 31 and 32 of this Agreement. The Manual revisions will also include a description of the documentation that must be submitted by the prescribing physician and

treating therapist, when seeking authorization for therapy services. The Agency will provide Plaintiffs' counsel with a copy of these revisions for review and comment prior to publication in the Medicaid Provider Procedures Manual. Any corrections or clarifications will be made in subsequent Texas Medicaid Bulletins.

34. Within ninety (90) days of the effective date of this Agreement, the Agency will publish an explanation of the policies described in paragraphs 31 and 32 of this Agreement in the Texas Medicaid Bulletin. The text to be published in the Bulletin will be provided to Plaintiffs' counsel for review and comment at least fourteen (14) days prior to the publication deadline.

35. The Agency will publish an explanation of the policies described in paragraphs 31 and 32 of this Agreement in the 2002 Medicaid User's Guide. This information will also be highlighted in a letter to be included with the Medicaid User's Guide. The User's Guide and the text of the letter will be provided to Plaintiffs' counsel for review and comment at least fourteen (14) days prior to the publication deadline.

V. Additional Terms and Provisions

A. Medicaid User's Guide and Hotline

36. The Agency will update and improve the Medicaid User's Guide on an annual basis.

37. The Agency will make reasonable good faith efforts to provide beneficiaries who contact its contractor's toll-free Medicaid Hotline with consistent, detailed information regarding the following: (a) the intended action; (b) the basis for the intended action; (c) the procedure for requesting a fair hearing; and (d) accessing medical case management services.

B. Training

38. The Agency will train its relevant staff concerning all requirements of this Agreement within ninety (90) days of its effective date.

39. The Agency will require its contractor to train its relevant staff concerning all requirements of this Agreement within ninety (90) days of its effective date.

40. The Agency will approve the contractor's curriculum and verify that the training has been conducted for all relevant staff.

41. The Agency will provide copies of all training materials to Plaintiffs' counsel prior to the training sessions.

42. Plaintiffs' counsel may observe one (1) Agency training and one (1) contractor training conducted pursuant to this Agreement.

C. Reporting

43. The parties acknowledge the importance of mutual communication during the implementation of the terms of this Agreement. To ensure effective and timely communication regarding the changes to the state's Medicaid programs necessitated by this Agreement, the Agency or its counsel shall submit three (3) written status reports to Plaintiffs' counsel. These status reports shall provide detailed information as to all activities undertaken to fully implement the terms of this Agreement. The reports shall be provided according to the following schedule: ninety (90) days, one hundred and eighty (180) days and three hundred and sixty (360) days after the effective date of this Agreement.

44. For a period of two (2) years after the effective date of this Agreement, the Agency or its counsel shall submit to Plaintiffs' counsel quarterly reports concerning the following Medicaid services for EPSDT beneficiaries: private duty nursing services; home health skilled nursing visits; durable medical equipment and supplies; and occupational therapy, physical therapy and services for individuals with speech, hearing and language disorders. These reports shall identify the number of: requests for prior authorization; approvals of prior authorization requests; modifications of prior authorization requests; and denials of prior authorization requests. Agency expenditures for the identified services shall also be reported to Plaintiffs' counsel on a quarterly basis or as the data is typically reported in the regular course of business. These reports will be provided to Plaintiffs' counsel within fourteen (14) days from the date that the information from the previous quarter becomes available.

D. Monitoring and Verification

45. Each quarter, the Agency will provide Plaintiffs' counsel with copies of the following notices:

- (a) denials on the basis of no federal financial participation: all notices, not to exceed two hundred (200);
- (b) denials and reductions of therapy services: thirty percent (30%), or two hundred (200), whichever is less;
- (c) denials and reductions of all other services on the basis of no medical necessity: two hundred (200).

46. The notices described in (b) and (c) above will be selected randomly. All notices will be redacted, and will be provided for a period of two (2) years beginning six (6) months from the effective date of the Agreement.

E. Effective Date, Adoption and Approval of the Agreement by the Court

47. This Agreement is effective as of the date of the Court's approval and adoption of the Agreement.

F. Incorporation, Jurisdiction, and Enforcement

48. It is the intention of the parties that the Agreement be fully incorporated into an order of the Court and that the Court have exclusive jurisdiction over all matters relating to enforcement of the Agreement. This Agreement neither adds to nor subtracts from the court's jurisdiction.

49. In the event that any party fails to comply with any portion of this Agreement, the party alleging noncompliance may seek enforcement of the Agreement in the United States District Court for the Eastern District of Texas. Prior to seeking enforcement, and absent an emergency, the party alleging noncompliance will provide notice to the opposing party and will give them thirty (30) days to correct the alleged noncompliance.

50. Failure by a party to enforce any provision of this Agreement shall not be construed as a waiver of the party's right to enforce other provisions of the Agreement.

G. Dismissal of Certain Claims

51. Within thirty (30) days of the effective date of this Agreement, the parties will file with the Court a Joint Stipulation of Voluntary Dismissal, in accordance with Rule 41(a) of the Federal Rules of Civil Procedure. The Stipulation will dismiss with prejudice claims related to:

- (a) therapy services;
- (b) the provision of notice and an opportunity to request a fair hearing upon denial, reduction, or termination of a requested Medicaid benefit;
- (c) the adequacy of the written notices denying, reducing, or terminating a Medicaid benefit;
- (d) Medicaid fair hearing procedures; and
- (e) the contents of Medicaid fair hearing decisions.

52. The above provision and the Joint Stipulation of Voluntary Dismissal does not apply to the following issues:

- (a) the obligation to provide notices to parents or legal guardians of beneficiaries under the age of 18;
- (b) the continuation of prior-authorized services pending appeal;
- (c) the authority of hearing officers;
- (d) private duty nursing services;
- (e) personal care services; and
- (f) durable medical equipment and supplies.

H. Attorneys' Fees, Costs, and Expenses

53. Within fourteen (14) days of the effective date of the Agreement, Plaintiffs will submit to Defendants a request for reasonable attorneys' fees, costs, and expenses. Defendants will respond to this request within sixty (60) days of receipt. Within sixty (60) days of an agreement on fees,

Defendants will seek the approval of the Attorney General, the Governor, and the Comptroller of the State of Texas and, once approved, will forward a check made payable to Advocacy, Inc., 7800 Shoal Creek Blvd., Suite 171-E, Austin, Texas 78757. If the parties cannot agree on the amount of attorneys' fees, or the required approvals are not obtained, Plaintiffs may petition the Court for an award of reasonable attorneys' fees, costs, and expenses.

I. Counterparts

54. This Agreement may be executed in multiple counterparts, each of which, if fully executed, may be admitted in evidence as a duplicate original.

J. Binding

55. This Agreement is final and binding on the parties, including all principals, agents, administrators, representatives, successors, and assigns. Each party has a duty to so inform any such principal, agent, administrator, representative, successor or assign.

K. Execution of Agreement

56. Counsel for Defendants represent that they have been fully authorized by their clients to enter into and execute this Agreement, under the terms and conditions contained herein.

SIGNED on the dates indicated below:

MARYANN OVERATH
State Bar No. 00786851

Date: _____

PETER HOFER
State Bar No. 09777275

Date: _____

ADVOCACY, INCORPORATED
7800 Shoal Creek, Suite 171-E
Austin, Texas 78757
Tel. (512) 454-4816

MAUREEN O'CONNELL
State Bar No. 00795949

Date: _____

SOUTHERN DISABILITY LAW CENTER
1006 Elm Street
Austin, Texas 78704
Tel. (512) 474-9093

ATTORNEYS FOR PLAINTIFFS

JOHN CORNYN
Attorney General of Texas

HAROLD G. BALDWIN
First Assistant Attorney General

JEFFREY S. BOYD
Deputy Attorney General for Litigation

TONI HUNTER
Chief, General Litigation Division

EDWIN N. HORNE
State Bar No. 10008000
Assistant Attorney General
P.O. Box 12548, Capitol Station
Austin, Texas 78711
Tel. (512) 463-2120

Date: _____

ATTORNEYS FOR DEFENDANTS

NAMED PLAINTIFFS:

PATRICIA N.
Parent and next friend of Plaintiff Alberto N.
Date: _____

MARIA K.
Next friend of Plaintiff Alice F.
Date: _____

RITA D.
Parent and next friend of Plaintiff Keyaira R.-D.
Date: _____

KATHY C.
Parent and next friend of Plaintiff Kaitlyn C.
Date: _____

MARIE D.
Parent and next friend of Plaintiff Aaron D.
Date: _____

KAREN M.
Parent and next friend of Plaintiff Andrew M.

Date: _____

ALLEN W.
Parent and next friend of Plaintiff Evan W.

Date: _____

CHAVA W.
Parent and next friend of Plaintiff Evan W.

Date: _____

PATRICIA C.
Parent and next friend of Plaintiff Chelsea C.

Date: _____

EXHIBIT A

EXHIBIT A: SAMPLE NOTICE LETTER FOR DENIAL OF SERVICES - NO FFP

July 1, 2001

Address to: Medicaid beneficiary

Copy to: Requesting provider

Dear Medicaid Beneficiary:

Request: Family Living, Inc. has requested prior authorization to provide you the following service(s):

12 hours per day of home health services for the period of July 15, 2001 through September 15, 2001.

Date of request: June 25, 2001

Response to request: Denied

Reason: This request is denied because Family Living, Inc., the home health agency identified as the provider of these services, does not meet the surety bond requirements required by federal law. Because Family, Living, Inc. does not meet the surety bond requirements, federal financial participation is not available and Texas Medicaid cannot authorize the services.

In order to receive these services you must choose a provider that meets the requirements of the Medicaid program. You may obtain a list of Medicaid providers by contacting 1-[xxx-xxx-xxxx].

[Insert the following if it makes sense in the context of the denial. It does not make sense in the context of this particular sample.]Your provider has been sent a copy of this letter. You may want to discuss this decision with your provider to make sure your provider submitted all of the documents necessary to support your request.

Legal basis for this decision:

42 C.F.R. § 441.16

Texas Human Resources Code § 32.024(e)

Fair hearing: If you want to discuss this decision or if you want to ask for a fair hearing, you can contact us free of charge at 1-[xxx-xxx-xxxx]. An explanation of your right to a fair hearing is on the other side of this letter.

Additional assistance: If you need assistance in obtaining medical care, you may be eligible for medical case management services. For more information about medical case management, you may contact the THSteps Outreach and Information Hotline, free of charge at 1-877-THSTEPS (1-877-847-8377).

EXHIBIT A: SAMPLE NOTICE LETTER FOR DENIAL OF SERVICES

July 1, 2001

Address to: Medicaid beneficiary

Copy to: Requesting provider

Dear Medicaid Beneficiary:

Request: Acme Medical Supplies has requested the following medical nutritional product:

9-5081X Ensure, powder, 420 gram, 60 day supply

Date of request: June 25, 2001

Response to Request: Denied

Reason: Texas Health Steps policy 40.4.3.6 states that medical nutrition products must be prescribed by a physician and be medically necessary. To show that this product is medical necessary, documentation must include:

- * Identification of a metabolic disorder requiring a nutritional product **or**
- * Indication that part or all nutritional intake is through a tube **or**
- * Explanation of the medical condition that requires a medical nutritional product.

Documentation submitted by your provider indicates that you do not have a metabolic disorder and that you do not have any nutritional intake through at tube. Documentation submitted by your provider indicates that you have a daily caloric intake of 1800 calories, without nutritional supplements. This is an age appropriate diet and your provider did not submit information explaining why you need this medical nutritional product to supplement your daily diet.

Your provider has been sent a copy of this letter. You may want to discuss this decision with your provider to make sure your provider submitted all of the documents necessary to support your request.

Legal basis for decision:

42 U.S.C. § 1396d(r)(5).

Texas Health Steps policy 40.4.3.6

Fair hearing: If you want to discuss this decision or if you want to ask for a fair hearing, you can contact us free of charge at 1-xxx-xxx-xxxx,. An explanation of your right to a fair hearing is on the other side of this letter.

Additional assistance: If you need assistance in obtaining medical care, you may be eligible for medical case management services. For more information about medical case management, you may

contact the THSteps Outreach and Information Hotline, free of charge at 1-877-THSTEPS (1-877-847-8377).

EXHIBIT A: SAMPLE NOTICE LETTER FOR DENIAL OF SERVICES

July 1, 2001

Address to: Medicaid beneficiary

Copy to: Requesting provider

Dear Medicaid Beneficiary:

Request: Acme Therapy has requested prior authorization to provide you speech-language pathology services for the following time period: July 15, 2001 through January 15, 2001.

Date of request: June 25, 2001

Response to request: Denied

Reason: Texas Health Steps policy 40.4.12.3 states that to request an extension of services, the documentation should include a current physician signature, a summary statement of measurable progress made during the treatment period, and documentation indicating new treatment goals and anticipated measurable progress for the next treatment period. Therapy goals include improving function, maintaining function or slowing the deterioration of function.

Documentation submitted by your provider indicates that you have met all of the therapy goals related to your use of the Dynavox and does not include any new goals. Additionally, documentation submitted by your provider does not state that you require speech therapy services to maintain your current ability to use the Dynavox.

Your provider has been sent a copy of this letter. You may want to discuss this decision with your provider to make sure your provider submitted all of the documents necessary to support your request.

Legal basis for decision:

42 U.S.C. § 1396d(r)(5).

Texas Health Steps policy 40.4.12.3

Fair hearing: If you want to discuss this decision or if you want to ask for a fair hearing, you can contact us free of charge at 1-xxx-xxx-xxxx. An explanation of your right to a fair hearing is on the other side of this letter.

Additional assistance: If you need assistance in obtaining medical care, you may be eligible for medical case management services. For more information about medical case management, you may contact the THSteps Outreach and Information Hotline, free of charge at 1-877-THSTEPS (1-877-847-8377).

EXHIBIT A: SAMPLE PAGE 2 FOR ALL NOTICES

**YOU HAVE A RIGHT TO A FAIR HEARING
IF YOU DO NOT AGREE WITH THIS DECISION**

You must ask for a fair hearing within **90** days from the date of this letter. If you do not ask for a fair hearing before [insert date], you will lose your right to a fair hearing.

Your rights in a fair hearing are:

- The right to represent yourself, or have a lawyer, relative, friend, or other person represent you;
- Before the date of the hearing, you have the right to see your case file and all of the documents that are to be used by the agency at the hearing. The documents to be used at the hearing will be sent to you before the hearing;
- The right to either a telephone or in-person hearing;
- You can also ask us to conduct the hearing using written documents only - you would not have to participate in person.
- The right to accommodations for a disability, including interpreter services.
- The right to request a language interpreter.

A fair hearing is an informal process. If you do ask for a fair hearing, you will get another letter telling you where and when the hearing will take place. The letter will also explain what will happen at the hearing, and your rights at, and after, the hearing.

You can call us to talk about this letter, even if you are not sure you want a fair hearing. You can call us free of charge at **[toll free number]**, Monday to Friday, 8:00 a.m. to 5:00 p.m. This is the same telephone number you should call if you want to ask for a fair hearing, and if you need to request an accommodation for a disability, or interpreter services. You can also write us at the National Heritage Insurance Company (NHIC) Client Notification Office at:

[NHIC contact information]

EXHIBIT B

IN THE MATTER OF _____
DOCKET NO. XXXXX-XXXX-2001

Date of Hearing: June 25, 2001

Date of Decision: July 25, 2001

Appearances:

On behalf of Petitioner:

Ms. _____, grandmother of _____.
Cornelius Wyley, M.D., _____'s physician
Pamela Fox, OTR, _____'s occupational therapist

On behalf of the Agency:

Ms. Virginia Ness, R.N., NHIC representative

I. Statement of Issue

The issue raised in this hearing is:

Whether NHIC correctly reduced Petitioner's occupational therapy from twice a week to once a week.

II. Procedural History

On May 15, 2001, the Acme Rehabilitation Center submitted a request for prior authorization to provide Petitioner, _____, two sessions of occupational therapy per week for the time period June 1, 2001 through August 31, 2001. NHIC denied the request for two sessions per week and, instead authorized one session per week. NHIC sent a notice of the denial to Petitioner, dated May 20, 2001 stating that the "requested services are not medically necessary because the goals described in the documentation submitted by your provider can be met with the provision of one therapy session per week."

On May 23, 2001, Petitioner's grandmother, Ms. _____, requested a fair hearing. The hearing was held in-person on June 25, 2001. The record was held open for written statements from the parties, until July 5, 2001. The record was closed on July 6, 2001.

III. Summary of Evidence

A. Testimony:

The Agency has the burden of demonstrating that NHIC correctly reduced Petitioner's occupational therapy services. Ms. Virginia Ness, R.N., NHIC representative, testified that she reviewed the documentation submitted by Acme Rehabilitation Center in support of its request for prior authorization and that in her opinion, the goals described in the documentation could be met with the provision of one therapy session per week.

Ms. Ness, R.N. also testified that the provider failed to submit information regarding the percentage of appointments kept during each six month period and an assessment of family involvement in therapy.

Petitioner's grandmother, Ms. _____, testified that _____ is nine years old and has been receiving two sessions per week of occupational therapy for the past five years. Ms. _____ testified that the purpose of the therapy is to help her granddaughter increase her fine motor skills and maintain her flexibility.

Petitioner's physician, Dr. Wyley, testified that _____ has a diagnosis of cerebral palsy with spastic quadriparesis resulting in apraxia, hypotonicity of musculature and poor motor coordination. Dr. Wyley testified that he prescribed two sessions per week of occupational therapy so that _____ can meet the goals outlined in her therapy plan.

Petitioner's occupational therapist, Ms. Fox, OTR, described the goals in _____'s therapy plan and explained why, in her opinion, _____ requires two sessions per week of occupational therapy in order to meet these goals. Ms. Fox testified that given Petitioner's age and the severity of her contractures, one therapy session per week will not allow Petitioner to sufficiently increase her fine motor skills or decrease her hypotonicity.

B. Exhibits:

- P1. Dr. Wyley's prescription for occupational therapy for _____, dated May 10, 2001.
- P2. Occupational therapy evaluation and treatment plan for _____, dated May 12, 2001, Acme Rehabilitation Center.
- P3. Occupational therapy evaluation and treatment plan for _____, dated May 5, 2000 Acme Rehabilitation Center.
- P4. Occupational therapy evaluation and treatment plan for _____, dated April 30, 1999, Acme Rehabilitation Center.

- P5 Occupational therapy evaluation and treatment plan for _____, dated May 1, 1998, Acme Rehabilitation Center.
- P6 Brown, F.F., O.T., "Addressing Fine Motor Skills for Young Children with Cerebral Palsy," Journal of Pediatric Occupational Therapy, August, 1998.
- P7 Curriculum Vita, Samuel Wyley, M.D.
- P8 Curriculum Vita, Pamela Fox, OTR.
- P9 _____'s Medicaid Identification card.
- R1 NHIC denial notice, dated May 20, 2001.
- R2 Case notes, Virginia Ness, R.N., NHIC.

C. Post-Hearing Documents

- P10 Petitioner's written statement, dated July 1, 2001
- R3 Respondent's written statement, dated July 1, 2001

IV. Findings of Fact

- 55. The NHIC denial notice was mailed to Petitioner on May 20, 2001. The denial notice failed to indicate the agency policy or the accepted standard of medical practice upon which the denial was based. (Exhibit R1).
- 56. Petitioner's grandmother, Ms. _____ made a timely request for a fair hearing on May 23, 2001. (Exhibit R1 and testimony of Ms. _____).
- 57. _____ is an eligible Medicaid beneficiary under the age of twenty-one (21). (Exhibit P9).
- 58. _____ is nine years old and lives with her grandmother. She has a diagnosis of cerebral palsy with spastic quadriplegia resulting in apraxia, hypotonicity of musculature and poor motor coordination. (Testimony of Ms. _____, Dr. Wyley and Ms. Fox, OTR)
- 59. Dr. Wyley is a pediatrician who has specialized in treating children with physical disabilities for the past twelve (12) years. He has been _____'s treating physician for six years. (Exhibit P7 and testimony of Dr. Wyley).
- 60. Ms. Fox, OTR is a licensed occupational therapist, licensed in the state of Texas, and she has been an occupational therapist for fifteen years. Ms. Fox, OTR has been _____'s treating occupational therapist for four years. (Exhibit P8 and testimony of Ms. Fox).
- 61. Acme Rehabilitation Center is a Medicaid provider enrolled in the Texas Medical Assistance Program. (Testimony of Ms. Fox).

62. The NHIC representative, Virginia Ness, R.N., is a registered nurse; she is not an occupational therapist and she has never examined or treated Petitioner. (Testimony of Ms. Ness, R.N.).
63. _____ began receiving occupational therapy at the age of four. Treatment goals have been directed at addressing muscle tone, postural control, praxis and bi-lateral coordination. (Testimony of Ms. _____, Dr. Wyley, and Ms. Fox, OTR, Exhibits P2 -P5).
64. _____ has been receiving occupational therapy twice a week for five years and while she has made some progress, she continues to show significant weaknesses in her overall fine motor skills. (Testimony of Ms. Fox, OTR, and Dr. Wyley, Exhibit P2).
65. _____'s current occupational therapy goals are:
- a) to improve visual motor skills;
 - b) to increase upper limb speed and dexterity;
 - c) to improve balance between flexor and extensor musculature;
 - d) increase motor planning abilities;
 - e) enhance quality of movement; and,
 - f) increase functional shoulder, arm and hand control.
- (Testimony of Ms. Fox, OTR, Exhibit P2).
12. Ms. Ness, R.N., NHIC representative, did not identify any medical standard to support her opinion that _____'s treatment goals can be achieved with the provision of one therapy session per week. (Testimony of Ms. Ness, R.N.).
66. Petitioner requires occupational therapy in order to improve and maintain fine motor functioning. (Testimony of Dr. Wyley and Ms. Fox, OTR).
14. Petitioner requires two sessions per week of occupational therapy in order to achieve the goals set out in her therapy plan. (Testimony of Dr. Wyley and Ms. Fox, OTR).

V. Conclusions of Law

1. The Agency's denial notice, dated May 20, 2001, was legally deficient because it failed to identify the Agency policy or accepted standard of medical practice which supported the determination that the requested two sessions per week of occupational therapy were not medically necessary.
2. Ms. _____ timely filed this appeal pursuant to 1 TAC §357.5(d).
3. 42 U.S.C. §1396r(5) and 25 TAC §33.132 require the Texas Medical Assistance Program to provide all medically necessary services to Medicaid beneficiaries under the age of 21.

4. Occupational therapy is a benefit of the Texas Medical Assistance Program for Medicaid beneficiaries under the age of 21. Texas Medicaid Medical Policy 40.4.6.
5. Federal regulations define occupational therapy as services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and provided to a recipient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment. 42 C.F.R. §440.110
6. Texas Medicaid Medical Policy authorizes occupational therapy when documentation submitted by the beneficiary's treating physician and occupational therapist establishes treatment goals to improve function, maintain function or slow the deterioration of function. Texas Medicaid Medical Policy 40.4.6.
7. The percentage of appointments kept during each six month period and an assessment of family involvement in therapy are not eligibility criteria for occupational therapy within the Medicaid Medical Policy or in the statutes governing Medicaid.
8. Petitioner meets the eligibility criteria for occupational therapy, described in Texas Medicaid Medical Policy 40.4.6.
9. The Agency failed to offer sufficient evidence to support its decision denying two sessions per week of occupational therapy to Petitioner. 1 TAC §357.21.
10. The requested occupational therapy services are medically necessary and, therefore, the Agency must authorize the provision of two sessions per week of occupational therapy to Petitioner. 42 U.S.C. §1396r(5), 25 TAC §33.132 Texas Medicaid Medical Policy 40.4.6