State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
Post Office Box 1736
Romney, WV 26757

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

August 2, 2006

_____
_____
_____

Dear Ms. _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held July 27, 2006. Your hearing request was based on the Department of Health and Human Resources' decision to deny medical eligibility for Nursing Facility coverage.

In arriving at a decision, the State Hearings Officer is governed by the Public Welfare Laws of West Virginia and the rules and regulations established by the Department of Health and Human Resources. These same laws and regulations are used in all cases to assure that all persons are treated alike.

Eligibility for the Medicaid, Long Term Care Services is based on current policy and regulations. Some of these regulations state as follows: Medicaid, Long Term Care Services are provided to eligible Medicaid individuals who reside in a nursing care or ICF/MR facility. Individuals eligible for coverage under this group must qualify medically. The medical assessment must establish the existence of a specified number and level of care needs. A determination must also be made as to whether the individual requires active treatment. These criteria only address the appropriateness of placement, and not the provision of services. (West Virginia Income Maintenance Manual § 17.1 and 17.11 & 42 CFR) .

The information, which was submitted at your hearing, revealed that your physical and mental condition does require a sufficient number of services and the degree of care required to qualify for Nursing Facility level of care.

It is the decision of the State Hearings Officer to **reverse** the actions of the Department to deny medical eligibility for the Medicaid, Long Term Care Program.

Sincerely,

Sharon K. Yoho
State Hearing Officer
Member, State Board of Review

cc: Erika H. Young, Chairman, Board of Review
Emily Keefer, B.M.S.
Oretta Keeney, WVMI

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

_____ _____,

Claimant,

v. **Action Number: 06-BOR-1789**

West Virginia Department of Health and Human Resources,

Respondent.

DECISION OF STATE HEARING OFFICER

I. INTRODUCTION:

This is a report of the State Hearing Officer resulting from a fair hearing concluded on July 27, 2006 for _____ _____. This hearing was held in accordance with the provisions found in the Common Chapters Manual, Chapter 700 of the West Virginia Department of Health and Human Resources. This fair hearing was convened on July 26, 2006 on a timely appeal, filed May 2, 2006.

II. PROGRAM PURPOSE:

The Program entitled Medicaid Long Term Care (nursing facility services) is set up cooperatively between the Federal and State governments and administered by the West Virginia Department of Health & Human Resources.

Nursing Home Care is a medical service, which is covered by the State's Medicaid Program. Payment for care is made to nursing homes, which meet Title XIX standards for the care provided to eligible recipients. In order to qualify for Nursing Home Care, an individual must meet both financial and medical eligibility criteria.

III. PARTICIPANTS:

Claimants' Witnesses:
_____, claimant's daughter, speakerphone

Department's Witnesses:

Emily Keefer, Bureau of Medical Services, by speakerphone
Oretta Keeney, WV Medical Institute, by speakerphone

Presiding at the Hearing was Sharon K. Yoho, State Hearing Officer and a member of the State Board of Review.

IV. QUESTIONS TO BE DECIDED:

The question(s) to be decided is whether the Department was correct in determining ineligibility for the Medicaid, Long Term Care (Nursing Home) Program.

V. APPLICABLE POLICY:

West Virginia Long Term Care policy §508.2
West Virginia Income Maintenance Manual Chapter 17.11:

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:
D-1 West Virginia Long Term Care policy §508.2
D-2 Pre-Admission Screening (PAS) completed April 13, 2006
D-3 Notification of denial dated April 20, 2006

Claimant's Exhibits:
C-1 Daughters recommendations for claimant's care

VII. FINDINGS OF FACT:

1) Ms. _____ is a 96-year-old female who was recently transferred from a Nursing Home facility to a Personal Care Home facility due to the denial of Long Term Care services. Her family made an application for Long Term Care placement coverage under the Medicaid program and the [redacted] Center completed a re-Admission Screening Assessment (PAS) on April 13, 2006.

2) The Department reviewed this initial PAS, which assigned only four (4) qualifying deficits. These deficits were in the areas of bathing, dressing, bladder incontinence and medicating. The Department issued a denial notice on April 20, 2006. This denial prompted the request for a fair hearing.

3) Mr. _____'s has diagnosis of osteoporosis, hypertension, congestive heart failure, coronary artery disease, hypothyroidism, knee pain and urinary incontinence.

4) Issues brought up at this hearing were in the areas of orientation, walking, hearing and grooming.

5) Ms. _____ is suffering from short-term memory loss, but is aware of time and place.

6) The claimant is able to walk independently while using a walker. She is not able to go up or down steps or ramps on her own. The situations where she is faced with steps and ramps are outside of her home at Dr. appointments Etc.

7) She has some hearing loss, but this is not an area where a deficit could be awarded.

8) Ms. _____ is not able to wash her own hair, trim her fingernails or trim her toenails. Others must perform these tasks. Her caregivers wash her hair bi-weekly and her hairdresser washes her hair bi-weekly. Her daughter trims her fingernails and a podiatrist trims her toenails during visits to the Personal Care home where she resides.

9) WV Long Term Care Policy §508.2, Medical Eligibility:

> To qualify medically for the nursing facility Medicaid benefit, an individual must need direct nursing care twenty-four (24) hours a day, seven (7) days a week. The Bureau has designated a tool known as the Pre-Admission Screening form (PAS) to be utilized for physician certification of the medical needs of individuals applying for the Medicaid benefit.
>
> An individual must have a minimum of five (5) deficits identified on the PAS in order to qualify for the Medicaid facility benefit. These deficits may be any of the following:
>
> - Decubitus – Stage 3 or 4
>
> - Unable to vacate a building – a person is physically unable at all times, requiring one-person assistance with walking (Item 25i) or mentally incapable of leaving the building due to total disorientation, with a diagnosis of dementia, alzheimers, or related condition (Items 25g and 33).
>
> - The individual needs hands-on assistance with eating, bathing, grooming, dressing, transferring and walking.
>
> - The individual is totally incontinent of bowel or bladder. Total incontinence is when the individual has no control of bowel or bladder functions at any time.
>
> - The individual is totally disoriented to time and place or is comatose
>
> - The individual cannot navigate a wheel chair in the home and must not be able to walk in the home without physical assistance.
>
> - The individual has skilled nursing care needs in one or more of these areas: suctioning, tracheostomy, ventilator, parenteral fluids, sterile dressings or irrigations.
>
> - The individual is not capable of administrating his/her own medications.

The assessment tool designated by the Bureau for Medical Services must be completed, signed, and dated by a physician. It is then forwarded to the Bureau or its designee for medical necessity review. The assessment tool must be completed and reviewed for every individual residing in a nursing facility no matter what the payment source for services.

Each nursing facility must have an original pre-admission screening tool to qualify the individual for Medicaid and to meet the federal PASRR requirements. Should the receiving nursing facility fail to obtain an approved assessment prior to admission of a Medicaid eligible individual, the Medicaid program cannot pay for services. The individual cannot be charged for the cost of care during the non-covered period.

A new medical assessment must be done for Medicaid eligibility for the nursing facility resident for all of the following situations:

- Application for the Medicaid nursing facility benefit;
- Transfer from on nursing facility to another:
- Previous resident returning from any setting other than an acute care hospital;
- Resident transferred to an acute care hospital, then to a distinct skilled nursing unit, and then returns to the original nursing facility; and
- Resident converts from private pay to Medicaid.

9) West Virginia Income Maintenance Manual Chapter 17.11:
B. ESTABLISHING MEDICAL NECESSITY, THE PAS-2000

When the PAS-2000 is completed before payment for nursing facility services can be made, medical necessity must be established. The PAS-2000 is used for this purpose. The PAS-2000 is signed by a physician and is evaluated by a medical professional of the State's contracted level of care evaluator. The PAS-2000 is valid for 60 days from the date the physician signs the form. The 60-day validity period applies, regardless of the reason for completion, i.e., new admission, transfer to a different facility.

VIII. CONCLUSIONS OF LAW:

1) Policy §508.2 stipulates that five (5) deficits are required for a determination of medical eligibility for Medicaid Facility benefits. Documentation and testimony clearly concludes that this claimant should have been assessed an additional deficit for needing hands on assistance for grooming. This additional deficit would make the total number of deficits be the five (5) required for medical eligibility.

2) Ms. _____ does not require hands on assistance to ambulate in her home and she is not totally disoriented to time and place. No additional deficits should be given in these areas.

IX. DECISION:

After reviewing the testimony presented during the hearing and the examination of documents and policy presented, it is the finding of this Hearing Officer that the PAS evaluation should have awarded five (5) deficits and the Department should have approved the appliction. I am ruling to **reverse** the Department's action to deny the claimant's application for Long Term Care benefits.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 2nd Day of August, 2006.

_____

Sharon K. Yoho
State Hearing Officer