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

May 31, 2006

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____
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Dear: Ms. ____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held May 10, 2006. Your hearing request was based on the Department of Health and Human Resources' decision to terminate Long Term Care benefits.

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 at the time of February 13, 2006 Pre Admission Screening you did meet the medical criteria for Long Term Care benefits.

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.
____ ____
Christina ____, [redacted]

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

____,

Claimant,

v. **Action Number: 06-BOR-1197**

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 May 10, 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 May 10, 2006 on a timely appeal, filed February 23, 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
____, claimant's son
[redacted] Physical Therapist, [redacted]
[redacted] Activities Director, [redacted]
[redacted] Dietary, [redacted]

Clinical Care Mgr. RN,
Social Worker,

Department's Witnesses:
Emily Keefer, Bureau of Medical Services, by speakerphone
Oretta Keeney, WV Medical Institute, by speakerphone
Debbie Lilly, Psychologist, 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 February 13, 2006
D-3 Eligibility Determination dated February 16, 2006
D-4 Notification of denial dated February 16, 2006

VII. FINDINGS OF FACT:

1) Ms. ____ is an 82-year-old female who is currently residing at Rehabilitation and Nursing, Long Term Care Facility, of County.

2) Ms. ____ returned to her own home recently and attempted to take care of her own needs. She remained in her own home for a very short time and was not successful in being able to care for herself. Her son returned her to the Nursing facility. A new PAS was completed upon her return to the facility in February 2006. This PAS determined that Ms. ____ did not have the required five (5) deficits for Long Term Care eligibility.

3) The February 13, 2006 PAS assigned deficits in four (4) areas. Deficits were assigned for Ms. ____'s need for assistance in bathing, grooming, transferring and for medication administration.

4) In the area of Dressing, a level 1 was marked on the PAS. This was indicating that the claimant needs no assistance with dressing. Ms. ____ however; cannot put on her own shoes and socks. During the short time in her own home, she did not wear shoes and socks or remained in the ones which were put on her by someone else.

5) Ms. ____ can feed herself once the food is set up for her. She is not able to cut up the food on her plate. She requires much of her food to be ground up for her. Ms. ____ states that she cannot cut up her food. The PAS issued a level 1 for eating which indicates that the claimant needs no assistance with eating.

6) 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.

7) 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. The completed PAS assigned four (4) deficits in the areas of bathing, grooming, transferring and medicating. Testimony clearly concludes that this claimant is incapable of independently dressing and eating.

2) Item number 25 a. on the PAS should have been coded with a level 2 indicating that the claimant needs physical assistance for eating. It should have also been coded with a level 2 for dressing in item 25 c. indicating the need for physical assistance for dressing.

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 claimant should have been assessed with 6 (six) qualifying deficits. I am ruling to **reverse** the Department's action to deny the claimant's application for Long Term Care Medicaid benefits.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 31st Day of May, 2006.

____

Sharon K. Yoho
State Hearing Officer