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

June 14, 2006

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____
____

Dear Mr. ____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held June 1, 2006. Your hearing request was based on the Department of Health and Human Resources' proposed discontinuance of Medicaid coverage for Nursing Facility care.

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 not 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 **uphold** 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.
Elissa Eavenson, DHHR

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

____,

Claimant,

v. **Action Number: 06-BOR-1445**

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 June 1, 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 June 1, 2006 on a timely appeal, filed March 13, 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
[redacted] LPN, [redacted]
[redacted] MSW, [redacted]
[redacted] Health Care Surrogate, DHHR

____, claimant's friend
____, claimant's friend
Tara Gibson, Social Worker, [redacted] Manor
Jean Riley, MSW, [redacted] Manor

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 March 2, 2006
D-3 Eligibility Determination dated March 7, 2006
D-4 Notice of discontinuance dated March 7, 2006
D-5 Hearing request from Eavenson dated March 9, 2006

VII. FINDINGS OF FACT:

1) Mr. ____ is a 65-year-old male who is currently residing in the nursing facility, [redacted] Manor. A new Pre Admission Screening (PAS) was completed on March 2, 2006 due to a request for transfer to another facility.

2) Staff from [redacted] Manor completed the PAS and the facility's physician, Dr. [redacted] signed off on the PAS.

3) The Department reviewed this PAS, which assigned only three (3) qualifying deficits. These deficits were in the areas of bathing, dressing and medicating. The Department issued a denial notice on March 7, 2006. This denial prompted the claimant's health care surrogate, [redacted] of DHHR, to request a fair hearing.

4) Mr. ____ has primary diagnosis diabetes mellitus type II and Hyertension.

5) The issues raised by the claimant's witnesses were in the areas of walking, orientation and vacating.

6) Mr. ____'s walking was reported to have been unstable at times when his insulin was not adjusted correctly.

7) While the claimant was living in an apartment complex in the recent past, Mr. ____ assisted Mr. ____ with his insulin administration. Mr. ____ testified that he has in the past, helped Mr. ____ with walking when his insulin was not adjusted.

8) A level II psychological evaluation was completed on Mr. ____ at the nursing home on April 12, 2006. The results of this evaluation showed some cognitive disorders. The PAS reported that the claimant is oriented. The Department contends that cognitive disorders and orientation are not the same thing.

9) His witnesses raised a concern regarding Mr. ____'s ability to vacate in the event of an emergency. It was felt that Mr. ____ may not be able to assess the circumstance and might act appropriately.

10) 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.

11) 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 did not clearly conclude that this claimant should have been assessed any additional deficits.

2) Policy §508.2 states that a deficit is assigned for vacating if: "In the event of an emergency, the individual is mentally incapable of leaving the building due to total disorientation, with a diagnosis of dementia, Alzheimer's or related condition." Policy also provides that if the client is assessed at a level 3 in walking, then a deficit can be assessed for vacating. Mr. ____ does not qualify in either of these scenarios. He is able to walk unassisted and he is oriented.

3) Ms. ____ clearly is not an individual who needs direct nursing care twenty-four (24) hours a day, seven (7) days a week, which is set forth by policy as a necessary requirement for qualifying medically for Medicaid Long Term Care services.

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 Department followed policy in making the determination that Ms. ____'s does not qualify medically for Long Term Care Medicaid services. I am ruling to **uphold** the Department's action to discontinue the claimant's services 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 14th Day of June, 2006.

_____

Sharon K. Yoho
State Hearing Officer