State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
235 Barrett Street
Grafton WV 26354

January 23, 2006

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

_____ for _____
_____
_____

Dear Mr. _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held December 9, 2005. Your hearing request was based on the Department of Health and Human Resources/ West Virginia Medical Institute's determination in finding you medically ineligible for the Medicaid, Long Term Care Program (nursing facility services).

In arriving at a decision, the State Hearing 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.

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 evaluation assessment must establish the existence of a specified number and degree of functional care needs. (West Virginia Income Maintenance Manual § 17.1 and 17.11)

The information which was submitted at your hearing revealed that your medical condition as of the October 12, 2005 medical evaluation did require a sufficient level of care (5 functional deficits) to medically qualify you for participation in the Medicaid, Long Term Care Program. The information provided to the agencies (DHHR and WVMI) for use in determining eligibility was not reflective of your limitations or needs.

It is the decision of the State Hearing Officer to **reverse** the determination of October 13, 2005. Your medical eligibility for the Medicaid-Long Term Care Program was established. See part IX of the attached summery.

Sincerely,

Ron Anglin
State Hearing Examiner
Member, State Board of Review

cc: Chairman, Board of Review
Bureau for Medical Services, Emily Keefer

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES

_____,

Claimant,

vs. **Action Number 05- BOR- 6803**

West Virginia Department of Health & Human Resources,

Respondent.

SUMMARY AND DECISION OF THE STATE HEARING OFFICER

I. INTRODUCTION:

This is a report of the State Hearing Officer resulting from a fair hearing concluded on January 23, 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 originally convened on December 9, 2005 on a timely appeal filed October 18, 2005. It should be noted here that the claimant has been found not medically eligible for the Medicaid, Long Term Care Program.

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:

_____, daughter to claimant
_____, son- in- law to claimant
[redacted] claimant's current care provider (by phone)
Emily Keefer, BMS/ Program Manager- LTC (by phone)
Oretta Keeney, West Virginia Medical Institute (by phone)
Presiding at the hearing was Ron Anglin, State Hearing Examiner and a member of the State Board of Review.

IV. QUESTION TO BE DECIDED:

The question to be decided is whether the claimant was medically eligible for the Medicaid, Long Term Care Program?

V. APPLICABLE POLICY:

West Virginia Income Maintenance Manual § 17.1 and 17.11.
Medicaid Manual Chapter 500, § 508.2

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

E -1- Medicaid Policy 508- 508.3
E -2- PAS-2000, Medical Evaluation, and medical documentation, 10/12/05
E -3- Notification (of denial) October 13, 2005

VII. FINDINGS OF FACT:

1) A PAS-2000, medical evaluation dated October 12, 2005 (E-2) was evaluated by Dept of Health & Human Resources per West Virginia Medical Institute October 13, 2005. WVMI determined the claimant medically ineligible for the Medicaid, Long Term Care Program and claimant was notified October 13, 2005 (E-3).

2) The claimant's hearing request dated October 14, 2005 was received by the Bureau for Medical services October 18, 2005 and a hearing was convened December 9, 2005.

3) During the hearing, Exhibits as noted in Section VI were presented.

4) Testimony was heard from the individuals listed in section III above. All persons providing testimony were placed under oath.

5) The agency (BMS and WVMI) acknowledged qualifying functional deficits in bathing and medication administration based on the October 12, 2005 evaluation.

6) Evidence provided on behalf of the claimant reveals that he was in the nursing facility 7/3/05 to 10/23/05 and is currently residing in a personal care home. At the time of the claimant's nursing home placement: He required the assistance of one person with walking and getting out of bed or out of a chair. He had a stroke some time ago and has difficulty with use of his left hand therefore he cannot button, zip or tie his shoes nor can he perform nail care. His attempts at shaving, hair care and denture care are inadequate. He wore pads for continence while in the NH. The physician who signed the medical evaluation had only known the claimant since he entered the NH. While the claimant's condition did improve so that he could enter a personal care home it has now declined.

7) Medicaid Manual Chapter 500, Volume 15 § 508.2 states in part: 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 nursing facility benefit. These deficits may be any of the following:

- Stage 3 or 4 pressure ulcer
- In the event of an emergency, the individual is mentally or physically unable to vacate a building
- The individual needs hands on assistance with eating, bathing, grooming, dressing, transfer, and walking.
- The individual is incontinent of bowel or bladder more than three (3) times a week.
- 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, tracheotomy, ventilator, parenteral fluids, sterile dressings or irrigations.
- The individual is not capable either mentally or physically of administrating his/her own medications.

The assessment tool designated by the Bureau for Medical Services must be completed and 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.

VIII. CONCLUSIONS OF LAW:

1) 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. A tool known as the Pre-Admission Screening form (PAS) is utilized for physician certification of the medical needs of individuals applying for the Medicaid benefit. After submission of the PAS, it is then forwarded to the Bureau or its designee (WVMI) for medical necessity review. Evidence reveals that the required PAS was completed October 12, 2005 and evaluated by WVMI October 13, 2005 at which time the agency found qualifying deficits in bathing and medication administration.

2) Qualifying deficits are derived from a combination of assessment elements on the medical evaluation as follows: Pressure ulcer - Stage 3 or 4; in the event of an emergency, the individual ability to vacate a building; functional abilities of individual in the home (eating, bathing, grooming, dressing, continence, orientation, transferring, walking, wheeling); skilled needs; and the ability to self-administer medication. Evidence revealed that the claimant needed physical assistance in walking and required help rising from a chair. He had a stroke effecting use of his left hand prior to entering the NH. This factor affected his ability to button, zip and perform grooming tasks. This combination of physical limitations results in full deficits *walking* (1 person assist.), *grooming* (physical assist.), *dressing* (physical assist.), and *ability to vacate in an emergency*.

3) To medically qualify for the nursing home Medicaid benefit, an individual must have a minimum of five (5) qualifying deficits. The medical evaluation contained deficits in *bathing* and *medication administration*. Evidence presented during the hearing established additional qualifying deficits in *dressing, grooming, walking* and *vacating a building.*

IX. DECISION:

After reviewing the information presented during the hearing and the applicable policy and regulations, I am ruling to **reverse** the October 13, 2005 determination concerning the claimant's medical eligibility for Medicaid LTC Services. Evidence, establishes 5 fully qualifying deficits.

Evidence reveals that the medical evaluation of October 12, 2005 failed to provide a representative profile of the claimant's physical or mental limitations. Had the medical evaluation properly reflected the claimant's condition, medical eligibility would have been established as of the date of the medical evaluation. The effective date of the claimant's **medical eligibility** for the Medicaid Nursing Home Care Program is therefore - October 12, 2005.

The claimant's representative may contact the local DHHR office for completion of the additional portions of the application process.

X. RIGHT OF APPEAL

See Attachment.

XI. ATTACHMENTS

The Claimant's Recourse to Hearing Decision.

Form IG-BR-29.

ENTERED this 23rd day of January, 2006.

_____

RON ANGLIN
State Hearing Examiner

CLAIMANT'S RECOURSE TO ADMINISTRATIVE HEARING DECISION
For
Public Assistance Hearings,
Administrative Disqualification Hearings, and
Child Support Enforcement Hearings

A. CIRCUIT COURT

Upon a decision of a State Hearing Officer, the claimant will be advised he may bring a petition in the Circuit Court of Kanawha County within four months (4) from the date of the hearing decision.

The Court may grant an appeal and may determine anew all questions submitted to it on appeal from the decision or determination of the State Hearing Officer. In such appeals a certified copy of the hearing determination or decision is admissible or may constitute prima facie evidence of the hearing determination or decision. Furthermore, the decision of the circuit Court may be appealed by the client or petitioner to the Supreme Court of Appeals of the State of West Virginia.

B. THE UNITED STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against because of race, color, national origin, age, sex or handicap, write immediately to the Secretary of the United States Department of health and Human Services, Washington, D.C. 20201.

C. THE UNITED STATE DEPARTMENT OF AGRICULTURE

If you believe you have been discriminated against because of race, color, national origin, age, sex or handicap, write immediately to the Secretary of the Department of Agriculture, Washington, D.C. 20250.