State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
PO Box 6165
Wheeling, WV 26003

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

October 18, 2007

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_____
_____

Dear Mr._____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held October 11, 2007. Your hearing request was based on the Department of Health and Human Resources' denial of medical eligibility for 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 you have only four (4) qualifying deficits. To be eligible for Medicaid for Nursing Facility care, you must have five (5) qualifying deficits.

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

Sincerely,

Melissa Hastings
State Hearing Officer
Member, State Board of Review

cc: Erika H. Young, Chairman, Board of Review
Nora McQuain, B.M.S.

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

_____,

Claimant,

v. **Action Number: 07-BOR-1865**

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 October 11, 2007 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 October 11, 2007 on a timely appeal, filed August 8, 2007.

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:

Claimant's Witnesses
_____, Claimant
[redacted] Nursing Home Social Worker

Department's Witnesses:
Nora McQuain RN, Bureau of Medical Services
Oretta Keeney RN, WV Medical Institute

Cindy Knighten RN, Bureau of Medical Services (observing)

Presiding at the Hearing was Melissa Hastings, State Hearing Officer and a member of the State Board of Review.

All parties participated telephonically.

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 §508.1 and 508.2

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 West Virginia Long Term Care policy §508.1 and 508.2
D-2 Pre-Admission Screening (PAS) completed June 26, 2007
D-3 Notification letter dated June 28, 2007
D-4 Activities of Daily Living Flow Chart

VII. FINDINGS OF FACT:

1) Claimant is an 88-year-old male who is currently residing at the [redacted] Village skilled nursing facility. The Claimant is diagnosed with hypertension and osteoarthritis.

2) A Pre-Admission Screening form (PAS) was completed on June 26, 2007 by Dr. [redacted] (D2). This PAS assigned four (4) deficits in the areas of Bathing, Transferring, Walking and Medication Administration.

3) The Department reviewed this PAS, and issued a denial notice on June 28, 2007 (D3).

4) The only issue raised by the Claimant during the hearing was in the area of incontinence of the bladder.

5) Testimony from the Claimant indicates that he has an enlarged prostrate which causes him to have frequency and problems with urination. Wears a pad to prevent wetting his clothes when he cannot make it to the bathroom in time. Claimant's testimony indicates this is a problem several times per day. He does realize he has a need to urinate and does go to the bathroom but does not always make it in time.

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.

VIII. CONCLUSIONS OF LAW:

1) Policy §508.2 stipulates that five (5) deficits are required for a determination of medical eligibility for Medicaid Long Term Care Facility benefits. The PAS completed in June assessed four deficits..

2) The issue of incontinence of the bladder was raised during this hearing. Policy requires total incontinence to receive a deficit. Testimony received during this hearing indicates that Claimant does have issues with urinary incontinence but they are not severe enough to be categorized as total incontinence.

IX. DECISION:

It is the decision of the State Hearings Officer to **Uphold** the agency's decision to deny the Claimant's application for Medicaid for Long Term Care Facility benefits.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 18th Day of October, 2007.

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Melissa Hastings
State Hearing Officer