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

November 8, 2007

_____
c/o _____
_____
_____

Dear Ms. _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held October 30, 2007. Your hearing request was based on the Department of Health and Human Resources' proposed termination 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 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 terminate medicaid coverage 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
Nora McQuain, B.M.S.
Oretta Keeney, DHHR

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

_____,

Claimant,

v. **Action Number: 07-BOR-1880**

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 30, 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 30, 2007 on a timely appeal, filed July 31, 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:

Claimants' Witnesses:
_____, Claimant's daughter, MPOA
_____, Claimant's grandson

[redacted] RN, [redacted] Nursing Home (NH)
[redacted] RN, [redacted] NH

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

Representative for Claimant was [redacted] Ombudsman, Legal Aid

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 medical 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
ADW Policy, Attachment 14

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 July 12, 2007
D-3 Eligibility Determination dated July 18, 2007
D-4 [redacted] NH Resident Order Listing
D-5 Notice of termination dated July 18, 2007

VII. FINDINGS OF FACT:

1) The claimant is a 92-year-old female who had been residing in [redacted] Nursing Home for some time under the Medicaid program. She recently returned to her home to attempt to live outside of the Long Term Care facility. The attempt was unsuccessful and she was returned to the facility.

2) As policy requires, a new Pre-Admission Screening (PAS) was completed by the nursing facility staff to ensure that the claimant remained medically eligible for the Medicaid coverage for Long Term Care. On July 12, 2007 the NH staff completed a PAS and submitted it to the WV Medical Institute (WVMI) for evaluation. This PAS was evaluated by WVMI who determined that only three deficits could be assigned to

this claimant. These deficits were assigned for bathing, dressing and medication administration.

3) The Department issued a notice of proposed discontinuation of Medicaid coverage for Long Term care on July 18, 2007. This notice advised that five deficits are required for medical eligibility.

4) The claimant's witnesses raised issues regarding the areas of incontinence, grooming and vacating.

5) The claimant's daughter contends that the staff at the facility would not be fully aware of her mother's episodes of incontinence. She picks up her mother's laundry at the facility and takes it home to wash each week. Each week, she finds numerous pairs of underwear that have obviously been laid out to dry before being placed in the laundry bag. These underwear have the smell of urine on them. The claimant's daughter testified that her mother admitted to her that she always dribbles in her underwear on her way to the bathroom each morning and sometimes totally voids on the way. The Department noted that the NH ADL detail report, (Exhibit D-4) shows toilet usage to be independent.

6) The NH contracts the services of a podiatrist who comes to the facility to clip fingernails and toenails for the patients who cannot clip their own. This claimant cannot clip her own nails and is among the patients who received this service. She may be able to file her fingernails. If the NH did not have this podiatrist coming to the facility, a nurse at the facility would have to clip this claimant's nails. The claimant is able to accomplish most of her grooming needs without hands on assistance, but does need hands on assistance for her nail care. The Department noted that the NH ADL detail report shows the patient to be independent with personal hygiene.

7) The claimant ambulates using a walker and she would be able to ambulate out of the facility in the event of an emergency with the use of her walker. The PAS indicates that she would require guidance and supervision but no hands on assistance. Testimony reaffirmed this.

8) 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:
>
> #24- Decubitus – Stage 3 or 4

#25- In the event of an emergency, the individual is c) mentally unable or d) physically unable to vacate a building a) and b) are not considered deficits.

#26- Functional abilities of individual in the home.
Eating – Level 2 or higher (physical assistance to get nourishment, not preparation)
Bathing – Level 2 or higher (physical assistance or more)
Grooming – Level 2 or higher (physical assistance or more)
Dressing – Level 2 or higher (physical assistance or more)
Continence – Level 3 or higher (must be incontinent)
Orientation – Level 3 or higher (totally disoriented, comatose)
Transfer – Level 3 or higher (one person or two person assist in the home)
Walking – Level 3 or higher (one person assist in the home)
Wheeling – Level 3 or higher (must be Level 3 or 4 on walking in the home to use Level 3 or 4 for wheeling in the home. Do not count outside the home.)

#27 - The individual has skilled nursing care needs in one or more of these areas: suctioning, tracheostomy, ventilator, parenteral fluids, sterile dressings or irrigations.

#28- 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.

10) Aged/Disabled Waiver Policy Manual, Attachment 14, (PAS)

f. Cont. /Bowel	Level (1-Continent)	(2-Occas. Incontinent) less than 3 per wk (3-Incontinent)

VIII. CONCLUSIONS OF LAW:

1) Policy §508.2 states: 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 of Medical Services for the Department of Health and Human Resources has a tool known as the PAS used to determine if there is a need for twenty-four (24) hours a day, seven (7) days a week.

2) Policy §508.2 stipulates that five (5) deficits are required to be found using this PAS tool for a determination of medical eligibility for Medicaid Facility benefits. The PAS assessed three deficits. It was determined during the hearing that the PAS should have assessed an additional deficit in the area of incontinence. Policy regarding the completion of a PAS in Attachment 14 stipulates that total incontinence would mean three or more incidents per week. This claimant clearly has an incident each day. The nursing facility believed this claimant to be independent in toileting. This belief is due to the patient's ability to keep her incontinence episodes from the staff.

3) Evidence and testimony support that this claimant cannot clip her own nails and therefore; should have been assessed a deficit for grooming. The regular staff at the facility does not have to clip her nails only because they hire a podiatrist to come to the facility to do this task for patients who cannot do their own. This podiatrist clips this claimant's nails due to her inability to do this for herself. The claimant is able to accomplish most aspects of grooming without hands on assistance, but since she cannot do this activity she should be assessed a deficit in grooming.

4) Evidence and testimony in this hearing indicate that the nursing facility staff was not fully aware of this patients bladder functioning and may have not fully understood the Department's interpretation of independence in grooming. The addition of a deficit for both grooming and incontinence would make a total of five deficits, which qualifies the claimant for Medicaid nursing facility benefits.

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 Nursing facility staff did not complete an accurate PAS and therefore; the Department made the wrong decision in their determination that the claimant no longer qualifies medically for Long Term Care Medicaid services. I am ruling to **reverse** the Department's action to discontinue Medicaid coverage 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 8th Day of November, 2007.

_____

Sharon K. Yoho
State Hearing Officer