



State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
150 Maplewood Avenue
Lewisburg, WV 24901

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

November 2, 2007

Dear Ms. _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held October 23, 2007. Your hearing request was based on the Department of Health and Human Resources' decision to deny your medical eligibility for the Medicaid Long-Term Care Program.

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. 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. (BMS Policy Manual Section 508.2)

Information submitted at the hearing revealed that your medical evaluation did not require a sufficient level of care (five functional deficits) to medically qualify you for participation in the Medicaid Long-Term Care Program.

It is the decision of the State Hearing Officer to **uphold** the Department's determination that you are medically ineligible for the Medicaid Long-Term Care Program.

Sincerely,

Margaret M. Mann
State Hearing Officer
Member, State Board of Review

cc: Chairman, Board of Review
Nora McQuain, RN, Bureau for Medical Services, DHHR
Oretta Keeney, WVMI

Administrator, _____ Center

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES

_____,

Claimant,

vs.

Action Number 07-BOR-2108

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 October 23, 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 23, 2007 on a timely appeal filed September 5, 2007.

It should be noted here that the Claimant has been found medically ineligible 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:

_____, Claimant

_____, Health Care Surrogate

_____, LPN, _____ Center

_____, Director of Nursing, _____ Center

Nora McQuain, RN, Director of Facilities and Residential Care, BMS, DHHR (participating telephonically)

Presiding at the hearing was Margaret M. Mann, State Hearing Officer and a member of the State Board of Review.

IV. QUESTION TO BE DECIDED:

The question to be decided is whether the Claimant is medically eligible for the Medicaid Long-Term Care Program.

V. APPLICABLE POLICY:

Bureau for Medical Services Policy Manual Sections 508 & 508.2

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 Bureau for Medical Services 508, 508.1 and 508.2

D-2 Results of medical review by West Virginia Medical Institute (WVMI) – West Virginia Department of Health and Human Resources Pre-Admission Screening (PAS) dated 07/20/2007

D-3 West Virginia Medical Institute Notice of Denial for Long Term Care Admission Letter dated 08/20/2007

VII. FINDINGS OF FACT:

- 1) A PAS medical evaluation (Exhibit D-2) was completed for the Claimant July 20, 2007 to determine medical eligibility for the Medicaid Long-Term Care Program. It was determined that the Claimant, who currently resides at [REDACTED] Center, is medically ineligible for the Medicaid Long-Term Care Program.
- 2) The Claimant was notified of the denial of long-term care services in a letter dated August 20, 2007. (Exhibit D-3) It was found that the Claimant had deficiencies in three (3) areas. Those were mentally unable to vacate in the event of an emergency, needs physical assistance with bathing, and unable to administer medications.
- 3) Testimony from SS revealed that she does not feel the Claimant can care for herself, especially with her medications. The Claimant is content at the facility.
- 4) Testimony from SB, LPN, revealed that the Claimant is able to do a lot of things independently. However, she does need cueing at times. She needs physical assist with getting a shower. The CNA or nurse does her nail care. She does have early signs of dementia. The Claimant has no idea of what medication she takes and would not be able to administer her own medications. She has exhibited a lot of behavioral problems which include but not limited to being argumentative and throwing things. She is paranoid and SB does not feel the Claimant could get out in the event of a fire.
- 5) Testimony from AW revealed the Claimant isolates herself at the facility and won't come out of her room.
- 6) The monthly summaries for June and July 2007 show self-care for the Claimant under grooming. (Exhibit D-2)
- 7) Section 508 of the Bureau for Medical Services Policy Manual reads in part that the Department has established a process of evaluation to determine eligibility for long term care services under the Medicaid Program. The evaluation is made on each recipient from information supplied by a physician, recipient or family/representative, health care facility and/or eligibility worker in the local

Department of Health and Human Resources office. This determination for the Medicaid benefit for nursing facility residents is based on both medical and financial criteria. The Bureau for Medical Services or its designee is responsible for the medical necessity determination and the Bureau of Children and Families is responsible for the financial information. The determination must occur prior to payment for services. The date the benefit starts is the later of one of the following dates: 1) The date of application in the local DHHR office; 2) The date of the physician signature on the medical assessment tool; or the date of admission to the nursing facility. The local office is responsible for notifying the individual/representative, the Bureau and the nursing facility of the date Medicaid eligibility begins.

8) Bureau for Medical Services Policy Manual Section 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:

- #24 Decubitis- 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.
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#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 persons 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.
- Individual is not capable of administering 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 Medicaid Long-Term Care Program, policy specifies that an individual must require direct nursing care twenty-four (24) hours a day, seven (7) days a week. A tool known as the Pre-Admission Screening (PAS) form is utilized for physician certification of the medical needs of individuals applying for the Medicaid benefit. The PAS is completed and forwarded to the Bureau for Medical Services or its designee (West Virginia Medical Institute) for medical necessity review. Evidence reveals that a PAS was completed on July 20, 2007 and it was determined that the Claimant is medically ineligible for Medicaid Long-Term Care Services.
- 2) Policy holds that to medically qualify for the nursing home Medicaid benefit, an individual must have a minimum of five (5) qualifying deficits on the PAS. These deficits are derived from a combination of assessment elements on the medical evaluation. The Claimant's PAS revealed that she has three (3) qualifying deficits. These are she is mentally unable to vacate in the event of an emergency, needs physical assistance with bathing, and is unable to administer her medications.
- 3) Those testifying during the hearing addressed the Claimant's medical condition and voiced concerns about the Claimant's ability to live independently. However, none of the information prompted the awarding of any additional functional deficits specified in policy. Therefore, the Claimant continues to lack the five (5) functional deficits required for medical eligibility.
- 4) The Department's conclusion that the Claimant is medically ineligible for the Medicaid Long-Term Care Program is correct.

IX. DECISION:

It is the ruling of the State Hearing Officer to **uphold** the Department's decision to deny medical eligibility for the Medicaid Long-Term Care Program.

X. RIGHT OF APPEAL

See Attachment.

XI. ATTACHMENTS

The Claimant's Recourse to Hearing Decision.

Form IG-BR-29.

ENTERED this 2nd day of November, 2007.

Margaret M. Mann
State Hearing Officer

THE CLAIMANT'S RECOURSE TO HEARING DECISION

A. CIRCUIT COURT

An adverse decision of a State Hearing Officer is subject to judicial review through a Writ of Certiorari (West Virginia Code 53-3-1 et seq.) filed in the Circuit Court of Kanawha County within four (4) months from the date of the hearing decision.

The court may determine anew 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 may be appealed to the Supreme Court of Appeals of the State of West Virginia.

B. THE UNITED STATES 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 STATES DEPARTMENT OF AGRICULTURE

If the hearing decision involves food stamps and 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.