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

August 7, 2007

_____
for _____
_____
_____

Dear Ms. _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held July 17, 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 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
Nora McQuain, B.M.S.
Oretta Keeney, DHHR
[redacted] Esquire
[redacted] Esquire

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

_____,

Claimant,

v. **Action Number: 07-BOR-960**

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 July 17, 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 originally scheduled for April 19, 2007 rescheduled for May 20, 2007 and again rescheduled and convened on July 17, 2007 on a timely appeal, filed March 14, 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
[redacted] Ombudsman, Legal Aid, by speakerphone

[redacted] LPN, [redacted] Long Term Care Facility [redacted], by speakerphone
[redacted] Director of Social Services, [redacted] by speakerphone

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

Council for Claimant was [redacted] Legal Aid
Council for the Department was Nisar Kalwar

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:

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 February 13, 2007
D-3 Notice of discontinuance dated March 9, 2007

Claimant's Exhibits:
C-1 Record of Admission dated October 19, 2004
C-2 Physician Orders 2/13/07 – 2/28/07

Both the Claimant's council and the Department's council submitted written closing arguments, which were instructed by the Hearings Officer to be three pages or less and post marked on July 31, 2007. The Department's council did not adhere to these instructed guidelines and therefore, his written closing arguments were not reviewed.

VII. FINDINGS OF FACT:

1) The claimant is a 76-year-old female who is currently residing at [redacted] which is a long term care facility in [redacted] WV. She was last admitted to this facility in the year 2004. A Pre Admission Screening (PAS) was completed on

February 13, 2007 by staff at the [redacted] to determine if the claimant could qualify for Nursing Facility care covered by Medicaid.

2) The PAS indicated that the claimant had deficits in two of the thirteen possible areas. These deficits were identified in the areas of vacating a building and in administering medications. The areas of bathing, dressing and grooming were marked to indicate that the claimant could perform these duties by her self with some prompting. The area of walking was marked to show she could independently walk. The area of transferring was marked indicating she needed supervised and or the use of an assistive devise.

3) The WV Medical Institute reviewed this PAS and determined that the claimant did not meet the medical criteria necessary for Medicaid payment of long term care. Five deficits would be needed for approval and the PAS only identified two. A denial notice was mailed to the claimant on March 9, 2007.

4) The claimant has a primary diagnosis of Diabetes Mellitus 250.0 and secondary diagnosis of Schizophrenia. The claimant's glucose levels must be monitored frequently throughout the day and insulin doses adjusted accordingly. Exhibit C-2, Physician Orders supports the need for close monitoring of glucose levels and adjusted doses of insulin. She is prescribed four different medications to assist in maintaining her blood sugar levels. Witnesses for the claimant testified that her diabetes has never been stabilized.

5) The predominant issue raised by the claimant's witnesses was that without this very close monitoring of her diabetes, her blood sugar levels would fluctuate too high or too low. Significant testimony was provided to prove that if the close monitoring were not taking place, and the claimant's blood sugar levels were allowed to drop too low or raise too high that she would need hands on assistance for many of her daily living activities such as eating, bathing, dressing, grooming, transferring and walking.

6) There was no significant evidence or testimony provided to indicate that this claimant's blood sugar levels do drop or raise to the level where she is not able to perform her daily activities without assistance. Testimony supported that a dangerous drop or elevation is a rare event with this claimant. Staff from [redacted] reported how the claimant acts when her blood sugar drops very low, but did not indicate that this would be more than a rare occasion. This is obviously due to the close monitoring received by staff at the [redacted] Most testimony was regarding what the claimant **would** (emphasis added) not be able to do for her self **if** (emphasis added) she was not properly monitored and medicated. The PAS did provide that the claimant does need assistance with medications and the nursing staff at the [redacted] is currently providing these medications including the insulin.

7) 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.

8) 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 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 only two (2) deficits in vacating a building in the event of an emergency and in medicating. While it was proven that this claimant requires very close monitoring of her diabetic condition and needs regularly adjusted medication administered, documentation and testimony did not clearly conclude that this claimant should have been assessed any additional deficits. It was not proven that the close monitoring that the claimant requires must be provided by direct nursing care twenty-four (24) hours a day, seven (7) days a week.

3) While the claimant's witnesses attest that this claimant should have been assigned additional deficits in functional abilities such as eating, bathing, grooming, dressing, transferring and walking, evidence and testimony points to the need for very close monitoring of medication to ensure that the claimant retains her functional abilities to perform these daily living activities without hands on assistance from others.

4) The Department followed policies outlined in §508.2 and issued the proper decision in the application process.

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 the claimant did not, at the time of application, qualify medically for Long Term Care Medicaid services. I am ruling to **uphold** the Department's action to deny the claimant's application for 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 7th Day of August, 2007.

_____

Sharon K. Yoho
State Hearing Officer