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

April 30, 2007

_____
_____
_____
_____

Dear Ms. _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held April 25, 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
Pat Brown, DHHR

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

_____,

Claimant,

v. **Action Number: 07-BOR-969**

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 April 25, 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 April 25, 2007 on a timely appeal, filed March 22, 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
Pat Brown, claimant's Health Care Surrogate, DHHR
Betty Johnston, Social Service Coordinator, DHHR
[redacted] Nursing Manager, [redacted] Hospital

[redacted] Registered Nurse, [redacted] Hospital

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

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 January 11, 2007
D-3 Eligibility Determination dated January 12, 2007
D-4 Notice of discontinuance dated January 12, 2007

VII. FINDINGS OF FACT:

1) The claimant is a 46-year-old female who is currently residing at [redacted] Hospital. A Pre Admission Screening (PAS) was completed on January 11, 2007 by [redacted] Hospital staff to determine if the claimant could qualify for Nursing Facility care covered by Medicaid.

2) The claimant has resided in a Hospital setting more in the last two years than elsewhere. She is diagnosed with Dementia, Seizure Disorder, Schizoaffective Disorder, and Mild Mental Retardation (IQ 57). She also has left ear Deafness and Hypotension.

3) The Department reviewed this PAS, which assigned only one (1) qualifying deficit. This deficit was in the area of Medication.

4) The claimant's witnesses explained that as long as she remains properly medicated, she is able to take care of her own Activities of Daily Living. In the recent past, she has resided for a short time with her mother where her brother also resides. Her mother is elderly and is helping to taking care of the brother who also has some problems. The

claimant did not get along with her brother and was asked to leave. She also tried living with her sister who also has some problems. Neither one of these arrangements worked out. The local DHHR arranged for Adult Family Care Home placements and none of these has worked out. When the claimant gets upset about such things as not being able to watch TV, she will leave the home without notice. She will later be found, often times, in compromising circumstances.

5) The predominant issue raised by the claimant's witnesses was that without very close supervision and close monitoring of medication the claimant would qualify in many of the areas possible for deficits.

6) The Hospital setting where she is now residing is a lock down area of the Hospital.

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.

11) 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 stipulates that five (5) deficits are required for a determination of medical eligibility for Medicaid Facility benefits. The PAS assessed only one (1) deficit in Medicating. Documentation and testimony did not clearly conclude that this claimant should have been assessed any additional deficits.

2) 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 evidence and testimony did not conclude that this claimant requires this level of nursing care.

3) It is clear that this claimant clearly requires very close supervision and close monitoring of medication as opposed to direct nursing care.

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 does not 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 30th Day of April, 2007.

_____

Sharon K. Yoho
State Hearing Officer