State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
P. O. Box 970
Danville, WV 25053

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

August 8, 2008

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Dear Mr. ____________-:

Attached is a copy of the findings of fact and conclusions of law on your hearing held July 31, 2008. Your hearing request was based on the Department of Health and Human Resources' action to deny your medical eligibility 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 Medicaid, Long Term Care (Nursing Facility) Services is based on current policy and regulations and requires eligible individuals to meet both medical and financial criteria. 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 know as the Pre-Admission Screening form (PAS) to be utilized for physician certification of the medical needs of individual apply 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.

The information submitted at your hearing reveals that your medical condition does require a sufficient number of services and the degree of care required to qualify you for Nursing Facility level of care.

It is the decision of the State Hearings Officer to **reverse** the Department's decision to deny your participation in the Medicaid Long-Term (Nursing Home) Care Program based on medical eligibility.

Sincerely,

Cheryl Henson
State Hearing Officer
Member, State Board of Review

cc: Erika H. Young, Chairman, Board of Review
Nora McQuain, BMS

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

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Claimant,

v. **Action Number: 08-BOR-1379**

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 31, 2008 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 July 31, 2008 on a timely appeal filed May 12, 2008.

It should be noted that the Claimant's benefits have been continued pending the outcome of this hearing.

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
_______________, Claimant's grand-daughter
[redacted] Social Worker, [redacted] Nursing Home
[redacted] Regional Ombudsman

[redacted] Director of Nursing, [redacted]

Department's witnesses:

Nora McQuain, BMS, Department Representative
Stacy Holstein, WVMI
Kelly Johnson, Program Manager for Long Term Care, observing

It should be noted that the Department's witnesses participated telephonically

Presiding at the Hearing was Cheryl Henson, State Hearing Officer and a member of the State Board of Review.

IV. QUESTION TO BE DECIDED:

The question(s) to be decided is whether the Department was correct in determining that the Claimant fails to meet the medical eligibility criteria for participation in the Medicaid Long Term Care (Nursing Home) Program.

V. APPLICABLE POLICY:

West Virginia Income Maintenance Manual Sections 17.1 and 17.11.
West Virginia Medicaid Manual Section 508.2

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 West Virginia DHHR Policy Manual, Chapter §508.2 (Medicaid, Long-Term Care)
D-2 Pre-Admission Screening (PAS) completed May 1, 2008
D-3 Notice from WVMI dated May 5, 2008
D-4 Physician's determination of capacity
D-5 Skilled Nurses notes
D-6 MDS-P-B form
D-7 Physical Functioning Form, Nurses Note, and hearing request form

Claimant's Exhibits:

None

VII. FINDINGS OF FACT:

1) On or about May 5, 2008 the Department sent the Claimant a notification letter (D-3) which included the following pertinent information:

NOTE: YOUR REQUEST FOR LONG-TERM CARE (NURSING HOME) ADMISSION HAS BEEN DENIED.

REASON FOR DECISION: Eligibility for long-term care placement being funded by Medicaid requires that you have at least five (5) areas of care needs (deficits) that meet the severity criteria. Documentation does not reflect that you have 5 deficits at the level required. Your request for long-term care is being denied. The PAS (Pre-Admission Screening Form), reflected deficiencies that meet the severity criteria in areas identified below – Eating, Bathing, Dressing, and Administering Medications.

2) The Department cited Medicaid policy guidelines and presented testimony to explain how the policy was applied to the medical findings documented on the Claimant's PAS. According to witnesses, the Patient Care Coordinator for [redacted] Nursing Home along with the Claimant's physician completed the medical assessment (PAS) and their documentation was relied upon to identify the four (4) areas qualifying as deficits – Eating, Bathing, Dressing, and Administering Medications.

3) Witnesses for the Claimant testified that in the area of Grooming - he cannot clip his own nails, fingers or toes, and can't brush his own hair. The Claimant also stated he cannot shave himself. Testimony was provided to show that neither the Patient Care Coordinator nor the Claimant's physician have been educated on the policy that is used in evaluating each category on the Pre-Admission Screening form to determine functional abilities. Therefore, it is reasonable to believe that they did not have the understanding necessary to accurately evaluate the Claimant's functioning capacity according to policy.

4) Witnesses also raised questions in the area of Vacating a Building. Testimony from the Claimant's witnesses support that without his power wheelchair he could not vacate, and his eyesight is too poor. The Department rated him during the assessment as being able to vacate a building in an emergency "with supervision".

5) The Claimant's witnesses stated that in the area of Wheeling – the Claimant cannot wheel independently if his power chair isn't working. He has carpal tunnel and cannot operate manually.

4) West Virginia Income Maintenance Manual Chapter 17.11, B - ESTABLISHING MEDICAL NECESSITY, THE PAS-2000, states:

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 (WVMI). 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.

5) WV Long Term Care Policy §508.2, (Medical Eligibility) states as follows:

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 persons assist in the home)
  Walking – Level 3 or higher (one person or two persons 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 Individual has skilled needs in one or more of these areas – (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations.

  #28 Individual is not capable of administering 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) 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 form (PAS) is utilized for physician certification of the medical needs of individuals applying for the 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.

2) The PAS revealed that the Claimant has four (4) qualifying deficit in areas of Eating, Bathing, Dressing, and Administering Medications.

3) Additional evidence and testimony support the finding of an additional one (1) deficit in the area of Grooming. It is clear that the Claimant needs hands on assistance in performing this function. Evidence clearly indicates that the individuals completing the PAS did not have sufficient knowledge of the program to determine what functions are considered under "grooming", and thus were unable to properly determine the Claimant's functional capacity according to policy. In conjunction with the four (4) deficits already awarded, the Claimant has a total of five (5) qualifying deficits.

4) Whereas the Claimant exhibits deficits in five (5) of the specific categories of nursing services, the Claimant's medical eligibility for participation in the Medicaid Long-Term (Nursing Home) Care Program is established.

IX. DECISION:

It is the decision of the State Hearing Officer to **reverse** the actions of the Department in denying the Claimant's eligibility for participation in the Medicaid Long-Term Care (Nursing Facility) Program.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 8th day of August, 2008

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Cheryl Henson
State Hearing Officer