State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
PO Box 6165
Wheeling, WV 26003

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

August 4, 2008

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_____
_____

Dear Ms. _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held July 17, 2008. 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 you have only two (2) qualifying deficits. To be eligible for Medicaid for Nursing Facility care, you must have five (5) qualifying deficits.

It is the decision of the State Hearings Officer to **Uphold** the action of the Department to deny medical eligibility for the Medicaid, Long Term Care Program.

Sincerely,

Melissa Hastings
State Hearing Officer
Member, State Board of Review

cc: Erika H. Young, Chairman, Board of Review
Nora McQuain, B.M.S.

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

_____,

Claimant,

v. **Action Number: 08-BOR-1525**

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, 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 on July 17, 2008 on a timely appeal, filed June 9, 2008.

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
[redacted] Nursing Home Social Worker
[redacted] Nursing Home Social Worker

Department's Witnesses:
Nora McQuain RN, Bureau of Medical Services

Stacey Holstein RN, WV Medical Institute
Kelly Johnson, Social Worker, Bureau of Medical Services (observing)

Presiding at the Hearing was Melissa Hastings, State Hearing Officer and a member of the State Board of Review.

All parties participated telephonically.

IV. QUESTIONS TO BE DECIDED:

The question(s) to be decided is whether the Department was correct in determining ineligibility for the Medicaid, Long Term Care (Nursing Home) Program.

V. APPLICABLE POLICY:

West Virginia Long Term Care policy §508.1 and 508.2

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 West Virginia Long Term Care policy §508.1 and 508.2
D-2 Pre-Admission Screening (PAS) completed May 9, 2008
D-3 Notification letter dated May 23, 2008
D-4 Physician's Determination of Capacity dated May 21, 2008 with accompanying nurse's notes

VII. FINDINGS OF FACT:

1) Claimant is an 71-year-old female who is currently residing at the [redacted] Nursing Home. The Claimant is diagnosed with dyspnea, significant arthritis, pain and COPD.

2) A Pre-Admission Screening form (PAS) was completed on May 9, 2008 by Dr. [redacted] (D2). This PAS was reviewed by an RN from WVMI and assigned two (2) deficits in the areas of Bathing and Ability to Vacate the Building.

3) The Department reviewed this PAS, and issued a denial notice on May 23, 2008 (D3).

4) Testimony received from the Claimant and the social workers indicate that they have no disagreement with the physician's evaluation as reflected on the PAS (D2).

5) The Claimant's functional ability for wheeling was clarified by the evaluating nurse. The PAS completed by the physician indicated in section 26j that the Claimant was a level 4 in wheeling. Policy indicates that a level 4 in wheeling would qualify for a deficit if the individual was also evaluated at a level 3 or 4 in walking. In this case, the

physician evaluated claimant's ability to walk as a level 1 therefore a deficit could not be given for wheeling.

6) 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 - Individual has skilled nursing care 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 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.

VIII. CONCLUSIONS OF LAW:

1) Policy §508.2 stipulates that five (5) deficits are required for a determination of medical eligibility for Medicaid Long Term Care Facility benefits. The PAS completed in May assessed two deficits..

2) The Claimant and her representatives did not dispute any of the findings made by the physician and the reviewing nurse on the PAS.

IX. DECISION:

It is the decision of the State Hearings Officer to **Uphold** the agency's decision to deny the Claimant's application for Medicaid for Long Term Care Facility benefits.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 4th Day of August, 2008.

_____

Melissa Hastings
State Hearing Officer