State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
P. O. Box 2590
Fairmont, WV 26555

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

December 9, 2008

_____
_____
_____

Dear _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held December 2, 2008. Your hearing request was based on the Department of Health and Human Resources' action to deny your application for Medicaid Long-Term Care (Nursing Facility) benefits.

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.

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 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.

The information submitted at your hearing demonstrates that your medical condition requires a sufficient number of services and the degree of care necessary to qualify you for nursing facility level of care.

It is the decision of the State Hearing Officer to **reverse** the Department's action in denying your application for Medicaid Long-Term Care benefits based on medical eligibility.

Sincerely,

Thomas E. Arnett
State Hearing Officer
Member, State Board of Review

Pc: Erika H. Young, Chairman, Board of Review
Mary McQuain, Esq.
Michael Kelly, Esq.

BOARD OF REVIEW

_____,

Claimant,

v. **Action Number: 08-BOR-1824**

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 December 9, 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 originally scheduled to convene on October 2, 2008 but was rescheduled and convened December 2, 2008 on a timely appeal filed July 29, 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:

[redacted] Esq., Counsel for Claimant
_____, Claimant's sister
_____, Claimant's niece
_____, Director of Social Services, [redacted] Nursing Home
_____, Social Worker, [redacted] Nursing Home.
Mary McQuain, Esq., Counsel for Department (Participated telephonically)
Kelley Johnson, LSW, Long-Term Care Program Manager (Participated telephonically)
Stacy Holstine, RN, WVMI (Participated telephonically)

Presiding at the hearing was Thomas E. Arnett, 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 or not 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 Facility) Program.

V. APPLICABLE POLICY:

West Virginia Medicaid Manual, Chapter 500, Section 514

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

Exhibit 1	Pre-Admission Screening (PAS) form, dated June 30, 2008
Exhibit 2	Notice of Denial Determination by WVMI, dated July 15, 2008

Claimant's Exhibits:

Claimant's -1	Physician's Determination of Capacity and MDS dated May 27, 2008
Claimant's -2	Mental Illness Evaluation by [redacted] 8/1/08 & 8/28/08

VII. FINDINGS OF FACT:

1) In response to a Pre-Admission Screening (PAS) form completed on June 30, 2008 (Exhibit 1), the Claimant was notified that her application for Medicaid Long-Term Care benefits was denied (Exhibit 2). This notice states:

> **NOTICE:** YOUR REQUEST FOR LONG-TERM CARE (NURSING HOME) ADMISSION HAS BEEN DENIED.
>
> An evaluation of your current limitations related to your medical condition(s) was conducted based on the information submitted to WVMI on the Pre-Admission Screening (PAS) form. It has been determined **you are ineligible** for long-term care (nursing home) admission **based upon WV Medicaid criteria.**
>
> **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 3 areas identified below – Vacate a Building, Bathing and Dressing.

2) As indicated in the July 15, 2008 Notice of Denial, the Department, by counsel, stipulated that the June 30, 2008 PAS identifies only three (3) deficits. The Department further noted that the reviewing WVMI RN did not have access to any additional medical documentation.

3) The Claimant, by counsel, contended that she should have been awarded a deficit in grooming and administering medications and she is therefore medically eligible to participate in the Medicaid Long-Term Care Program.

4) Evidence submitted in support of a deficit in grooming includes Claimant's Exhibit-1, MDS (Minimum Data Set) that reveals on page 2 of 3, section G.1.j. that the Claimant requires extensive assistance / one person assistance with grooming activities. In addition to the MDS, a Nurse's Progress Note dated May 27, 2008 further confirms that the Claimant requires physical assistance in grooming activities. Based on the evidence, the PAS was marked incorrectly - the Claimant requires level 2 (physical assistance) with grooming and a deficit is therefore awarded.

5) The evidence reveals that the Claimant's mental capacity was evaluated (Physician's Determination of Capacity) and the determination was made that the Claimant does not have capacity to make medical decisions. Testimony presented on behalf of the Department indicates that the Claimant takes only "PO" medications (oral) and if the person is able to eat, he/she are capable of picking up a pill and placing it in he/she mouth. The WVMI RN further testified that it is not until later stages of Alzheimer's / dementia that individuals have difficulty following verbal prompts or refuse to take their medication.

Testimony received at the hearing reveals that the Claimant is "usually" compliant with prompting and supervision when medications are administered. It is noted in Claimant's Exhibit 2 (Mental Illness Evaluation) that the Claimant is unable to report what medications she is taking, the dosage or the frequency. The evaluator concludes that "…if the assistance is changed the likelihood of her confusing, misadministering [sic] and possibly not administering her medication is going to be a definite problem."

While the Claimant's "stage" of Alzheimer's / dementia is unclear, she has been determined mentally unfit to make her own medical decisions and the evaluating psychologist concluded that she is incapable of administering her own medications without assistance. In addition, if the Claimant is "usually" compliant with prompting and supervision, there are clearly periods when she is not. It is during these occasions that she would require more than prompting and supervision. Based on the evidence, the Claimant cannot administer her own medications.

6) WV DHHR Medicaid, Long Term Care Policy §514.8, states as follows:

> 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 determination.

The determination must occur prior to payment for services. The date the benefit starts is the later of one of the following dates:

- The date of application in the local DHHR office;
- 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.

514.8.1 APPLICATION PROCEDURE

An application for nursing facility benefits may be requested by the resident, the family/representative, the physician, or a health care facility. The steps involved in approval for payment of nursing facility services are:

- The application for NF services is made to the local DHHR office. The determination of financial eligibility for Medicaid is the responsibility of the local office; and
- The medical eligibility determination is the responsibility of the Bureau for Medical Services based on a physician's assessment of the medical and physical needs of the individual. This assessment must have a physician signature dated not more than sixty days prior to the start of services.

514.8.2 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. See Attachment. 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: 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 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 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.

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 Medicaid recipient who converts from Medicare Part A coverage to Medicaid does not need a new assessment to receive the Medicaid benefit. Medicaid coverage can be reinstated as long as a Medicaid denial letter has been issued.

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 one 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 in order to qualify medically. These deficits are derived from a combination of assessment elements on the PAS completed by the evaluating physician.

2) The June 30, 2008 PAS reveals that the Claimant demonstrated three (3) program qualifying deficits.

3) The evidence submitted at the hearing identifies two (2) additional program qualifying deficits in the areas of grooming and administering medications.

4) Whereas the Claimant demonstrates five (5) qualifying deficits, the Claimant is medically eligible to participate in the Medicaid Long-Term Care program.

IX. DECISION:

It is the decision of the State Hearing Officer to **reverse** the Department's action to deny the Claimant's application for Medicaid Long-Term Care (Nursing Facility) benefits.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 9th Day of December, 2008.

_____

Thomas E. Arnett
State Hearing Officer