State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
P. O. Box 468
Hamlin, WV 25523

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

November 20, 2008

_____
_____
_____

Dear _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held October 28, 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
Katherine Nester
[redacted] Nursing and Rehabilitation
Kelley Johnson, BMS

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

_____,

Claimant,

v. **Action Number: 08-BOR-2067**

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 October 28, 2008 for [redacted] 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 June 24, 2008 on a timely appeal filed April 22, 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 daughter
_____, Ombudsman, observing
[redacted] Social Worker, [redacted] Nursing and Rehabilitation

Dr. [redacted] Medical Director, [redacted] Nursing and Rehabilitation, participated by telephone

Department's witnesses:

Kelley Johnson, BMS, Department Representative, participated by telephone
Jenny Craft, WVMI, participated by telephone

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 514.8, 514.8.1 and 2

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 West Virginia DHHR Policy Manual, Chapter §514.8, 514.8.1 and 2
D-2 Pre-Admission Screening (PAS) completed August 22, 2008
D-3 Notice from WVMI dated August 25, 2008
D-4 Physician's determination of capacity and various forms

Claimant's Exhibits:

None

VII. FINDINGS OF FACT:

1) On or about August 25, 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 2 areas identified below – Bathing 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 the Department's representatives, the Registered Nurse Supervisor completed the medical assessment (PAS) and her documentation was relied upon to identify the two (2) areas – Bathing and Administering Medications – qualifying as a deficit.

3) The Claimant's representatives dispute the Department's findings in the following areas:

Vacating a Building: The Claimant was rated as being able to vacate a building in the event of an emergency "with supervision". Witnesses for the Claimant testified that he moves very slowly with a walker and would not know which way to go. He "shuffles" and would take ten to fifteen minutes to get out on his own. He needs assistance opening up his walker as his hands are drawn and numb. The Director of Social Services stated that in the event of an emergency someone would probably physically help the Claimant leave the building because of his poor movement capabilities. The Department points to a quarterly assessment form (D-4) which shows the claimant was rated as being able to walk in his room independently. The form also shows that the Claimant was rated as needing "one person assistance" in "locomotion on and off the unit".

Dressing: The Claimant was rated as being able to dress with "self/prompting". Witnesses for the Claimant testified that he can't reach behind his body to pull pants up. He can't put his socks on or button clothing. His fingers are numb and he cannot "feel" and has trouble grasping things. The Claimant's daughter testified that when she is there with him she must pull his pants up for him, as well as his socks. The Department's quarterly assessment form (D-4) shows under dressing that he was rated as needing physical assistance in this area.

Grooming: The Claimant was rated as "self/prompting". Witnesses for the Claimant testified that he can't hold a toothbrush, wash cloth, or shave himself. He needs assistance with cleaning after bowel movements, as well as with shampooing and combing his hair. The Claimant's daughter testified that she washes and combs his hair when she comes to visit him. The Department's quarterly assessment form (D-4) shows under "personal hygiene" that the Claimant was rated as needing one person physical assistance in this area.

Transferring: The Claimant was rated as transferring "independently". Witnesses for the Claimant report that he cannot open his wheelchair, and has difficulty getting out of bed, although he is able to do this without assistance at this time.

Walking: the Claimant was rated as walking with "supervised/assistive device". Witnesses for the Claimant report that he uses an assistive device, and he shuffles, walking very slowly. The Claimant testified that he cannot walk very far so he does not, because he has too much pain.

The Physician Medical Director for [redacted] Nursing and Rehabilitation testified that he visits the facility once a week, and when he sees the Claimant he is typically in the bed. He stated that the Claimant and his family has told him repeatedly that he needs physical assistance with

dressing, making it to the bathroom and cleaning afterward. The physician stated he believes the reports from the Claimant and his family and they are consistent with his medical condition. He also stated that the reports from the Claimant are not supported by the nurse's documentation; however, he notes he has had frequent documentation issues with the nurses in this particular facility.

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 §514.8 (Resident Eligibility Requirements) and §514.8.2 (Medical Eligibility) 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. These deficits are derived from a combination of assessment elements on the medical evaluation.

2) The PAS revealed that the Claimant has two (2) qualifying deficits in areas of Bathing and Administering Medications.

3) The evidence and testimony clearly support the finding of additional deficits in the areas of vacating the building in the event of an emergency, dressing, and grooming. In conjunction with the two (2) 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 20th day of November, 2008

_____

Cheryl Henson
State Hearing Officer