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

January 15, 2008

_____ for _____ _____
_____
_____

Dear Ms. _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held December 19, 2007. Your hearing request was based on the Department of Health and Human Resources'proposed action to terminate Medicaid payment for long term nursing facility services for your brother, _____.

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 five (5) qualifying deficits and are be eligible for Medicaid for Nursing Facility care.

It is the decision of the State Hearings Officer to **Reverse** 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: 07-BOR-2415**

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 19, 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 December 19, 2007 on a timely appeal, filed October 24, 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:

Claimant's Witnesses
_____ – Claimant's sister and Power of Attorney
_____ – Claimant's brother-in-law
_____ - Social Worker [redacted] Nursing Home
_____ _____ of [redacted] Assisted Living Facility
[redacted] MD – Claimant's attending physician

Department's Witnesses:
JoAnn Ranson, RN - Bureau of Medical Services
Oretta Keeney, RN - WV Medical Institute

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

Note: Claimant's benefits are continuing pending the hearing decision.

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 October 3, 2007
D-3 Notification letter dated October 4, 2007
D-4 Activities of Daily Living Detail Report

Claimant's Exhibits:
C-1 Letter from Claimant's sister/power of attorney
C-2 Listing of Facts and Concerns for Claimant by sister/ power of attorney
C-3 Personal Journal dated October 1, 2007 through November 28 , 2007 prepared by sister/Power of attorney
C-4 Letter dated December 5, 2007 from [redacted] MD
C-5 Letter dated November 11, 2007 from _____ [redacted]
C-6 Letter dated December 4, 2007 from _____, Case Manager [redacted] Systems
C-7 Medical report dated October 22, 2007 from [redacted] MD
C-8 Medical report dated October 18, 2007 from [redacted] MD
C-9 Physical Therapy report dated November 7, 2007
C-10 Standard Progess Note dated July 11, 2007 from the Crisis Stabilization Unit [redacted] Treatment and Support Center
C-11 _____Nursing Home Consultation Report dated November 26, 2007
C-12 Photo Exhibit of Claimant from 2003 through 2007
C-13 Psychiatric Evaluation dated November 26, 2007 from [redacted] MD

VII. FINDINGS OF FACT:

1) Claimant is a 66-year-old male who is currently residing at the [redacted] Nursing Facility. A Pre-Admission Screening from was completed on September 5, 2007 and he was approved for Medicaid for Long Term Care services. He was admitted to the [redacted] Facility on September 25, 2007 after living for several years in the [redacted] assisted living facility. The Claimant is diagnosed with schizophrenia and dementia.

2) A second Pre-Admission Screening form (PAS) was completed on October 3, 2007 by [redacted] (D2) because officials at the [redacted] Nursing Home felt the Claimant's condition had changed since his initial admission. This PAS assigned two (2) deficits in the areas of Bathing and Medication Administration.

3) The Department reviewed this PAS, and issued a denial/closure notice on October 4, 2007 (D3).

4) Claimant's representative contends that deficits should have been awarded to the Claimant in the following areas:

Ability to Vacate the Building in the event of an emergency
Grooming
Dressing
Continence
Orientation
Transfer
Walking
Wheeling.

5) **Ability to Vacate the Building in the event of an emergency** – Item 25 of the PAS addresses this issue. The physician completing the document has marked
b. With Supervision

Claimant's representatives indicate that Claimant suffers dizziness when walking and is very confused. His attending physician's testimony indicates Claimant could not find his way out of the building. Testimony from the nursing facility's social worker indicates that Claimant has to be taken by wheelchair to the dining room as he cannot walk the distance on his own.

6) **Grooming** – Item 26 d of the PAS addresses the issue of grooming. The physician completing the document has assigned a level 1 Self/Prompting for this area.

Claimant's representative indicates that Claimant cannot shave or comb hair himself. His attending physician's testimony indicates that Claimant has the physical ability to meet his grooming needs but his mental condition makes it impossible for him to stay on task long enough to complete the process. May shave only one side of his face for example. The ADL Detail Report (D4) for Personal Hygiene shows that Claimant does complete this task independently at times but also has required a one person physical assist and limited assistance as well. The letter from Dr. [redacted] (C4) states that it is necessary for staff to shave him. In addition, the letter from [redacted] Health Systems

(C6) states that Claimant cannot reliably be expected to carry on any independent activities such as bathing, shaving, dressing, oral care, etc.

7) **Dressing** - Item 26 c of the PAS addresses the issue of dressing. The physician completing the document has assigned a level 1 Self/Prompting for this area.

Claimant's representative indicates that Claimant can physically dress himself but cannot concentrate long enough to complete the task. Testimony from the [redacted] Administrator indicates that when Claimant was a resident at his facility he would not put clothes on appropriately. A shirt may be put on backwards for example. If clothes were set out for him to put on Claimant would make an attempt to put them on but they may not be appropriate. Dr. [redacted]'s letter (C4) states Claimant may have periods of incontinence and would not clean himself and put the same clothing back on. In addition, the letter from [redacted] Health Systems (C6) states that Claimant cannot reliably be expected to carry on any independent activities such as dressing. The ADL Detail Report (D4) shows that between September 25, 2007 and October 5, 2007 Claimant required a one person assist in the evening of September 27, 2007 and in the morning on October 3, 2007. All other times were marked as independent.

8) **Continence of Bowel** – Item 26 f of the PAS addresses the issue of bowel continence. The physician completing the document has assigned a level 1 Self/Prompting for this area.

Claimant's representative indicates that prior to entering the nursing facility Claimant was experiencing bowel incontinence 3 to 4 times per week. Since his entry into the nursing home he had had only one accident. Testimony from the nursing home social worker indicates that they have him on a toileting schedule which has prevented the accidents from occurring.

9) **Orientation** – Item 26 g of the PAS addresses the issue of orientation. The physician completing the document has assigned a level 1 Oriented for this area.

Claimant's representative acknowledges that Claimant is not comatose. His attending physician's testimony indicates that Claimant know who he is but is not always oriented to time. As far as orientation to place, the attending physician's testimony indicates Claimant may not know the name of the place he is in but knows where he is. Medical reports all indicate that Claimant suffers hallucinations at time due to his mental illness.

10) **Transferring** – Item 26 h of the PAS addresses the issue of transferring. The physician completing the document has assigned a level 1 Independent for this area.

Claimant's representative indicates that Claimant's dizziness affects his ability to transfer on his own. The ADL Detail Report (D4) for the time period of September 25, 2007 through October 31, 2007 for Bed Mobility shows that Claimant functioned independently in this area. For the time period of September 25, 2007 through October 1, 2007 in the area of Transfer the ADL Detail Report (D4) shows supervision was needed twice on September 27 to accomplish transfer. All other times Claimant performed transfer independently.

11) **Walking and Wheeling** - Item 26 i and j of the PAS addresses the issue of walking and wheeling. The physician completing the document has assigned a level 2 Supervised/Assistive Device for the area of walking and a level 1 No Wheelchair for the area of wheeling.

Claimant's representative indicates that Claimant has an unsteady gait and suffers dizziness when walking. Does ambulate at times independently by holding onto railings in the nursing home's hallways. Testimony received from the nursing home's social worker indicates that Claimant must be pushed in a wheelchair to the dining room as he cannot ambulate independently that distance. Claimant's representative also indicates that Claimant utilizes a wheelchair on his own at times but cannot operate the hand controls. Uses his feet to move the wheelchair. The ADL Detail Report (D4) for Locomotion in Unit from September 25, 2007 through September 30, 2007 shows that Claimant functioned independently in this activity on September 25 and 26. However the report shows supervision or one person physical assist for the test of the time period.

12) 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 the individual in the home.
>
> Eating – Level 2 or high (physical assistance to get nourishment, not preparation)
>
> Bathing – Level 2 or high (physical assistance or more)
>
> Grooming – Level 2 or high (physical assistance or more)
>
> Dressing – Level 2 or higher (physical assistance or more)
>
> Continence – Level 3 or high (must be incontinent)
>
> Orientation – Level 3 or high (Totally disoriented, comatose)
>
> Transfer – Level 3 or high (one person or two person assist in the home)

Walking – Level 3 or higher (one person assist in the home)

Wheeling – Level 3 or high (must be a 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) 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 on October 3, 2007 assessed two (2) deficits in the areas of bathing and medication administration.

2) The issues of vacating a building in the event of an emergency, grooming, dressing, bowel continence, orientation, transfer, walking and wheeling were are under dispute in this hearing.

3) Testimony and documentary evidence provided during this hearing reveal that Claimant does have qualifying deficits in the following disputed areas:

Vacating a building in the event of an emergency – It is clear that Claimant's mental and physical abilities would prevent him from successfully vacating a building in an emergency. A wheelchair is required to transport him to the dining area for meals as he cannot walk that distance himself therefore it can be assumed he would require at the very least a one person assist or possibly a wheelchair to vacate a building in case of an emergency.

Grooming – The ADL reports from the nursing facility as well as medical reports from physicians all show that Claimant requires physical assistance to accomplish the task of shaving himself.

Walking - The ADL reports from the nursing facility show that in a 6 day period from September 25 through September 30, 2007, the Claimant was only able to ambulate independently twice. The rest of the time the report shows he required a one person assist or supervision. In addition, testimony from the nursing home social worker confirms that Claimant cannot ambulate independently to the facility's dining room. He must be transported via wheelchair. Policy does not indicate that a level 3 for walking requires the individual to require a one person assist at all times. It does appear the Claimant requires a one person assist the majority of the time.

IX. DECISION:

It is the decision of the State Hearings Officer to **Reverse** the agency's decision to deny the Claimant's application for Medicaid for Long Term Care Facility benefits. The agency initially awarded the Claimant two (2) deficits for bathing and medication administration. The hearings officer has determined that three (3) additional deficits should be awarded for Vacating the building in the event of an emergency, grooming and walking. The total number of deficits awarded is five (5) which meets the program requirements.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 15th Day of January, 2008.

Melissa Hastings
State Hearing Officer