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

March 17, 2008

_____ for
_____
_____
_____

Dear Ms._____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held March 4, 2008. Your hearing request was based on the Department of Health and Human Resources' proposal to terminate your benefits through the Medicaid Long-Term Care (Nursing Facility) Program.

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 reveals that your medical condition no longer requires 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 Hearing Officer to **uphold** the Department's proposal to terminate your Medicaid Long-Term Care benefits based on medical eligibility.

Sincerely,

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

cc: Erika H. Young, Chairman, Board of Review
Nora McQuain, RN, BMS
[redacted] Ombudsman

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

_____,

Claimant,

v. **Action Number: 07-BOR-2512**

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 March 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 March 4, 2008 on a timely appeal filed November 8, 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:

Chris Rine, Ombudsman
_____, Claimant's Son, MPOA
_____, Claimant's Daughter-in-law
_____, Claimant's Daughter-in-law
_____, Administrator, [redacted] Health Care Center
[redacted] LSW, [redacted] Health Care Center
[redacted] RN, Clinical Care Manager, [redacted] Health Care Center

Nora McQuain, RN, BMS (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: (1) Whether a new PAS (medical assessment) should have been completed on the Claimant and (2) 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 Facility) program.

V. APPLICABLE POLICY:

West Virginia Income Maintenance Manual, Chapter 17
West Virginia Medicaid Manual, 508, 508.1 and 508.2
Code of Federal Regulations 42 CFR §483.20

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 West Virginia Medicaid (WV Provider Manual) Policy Manual, 508, 508.1 and 508.2 (Medicaid, Long-Term Care)
D-2 Pre-Admission Screening (PAS) completed October 16, 2007
D-2a Monthly ADL Flowsheet (October 2007), Nurses Note's 9/13/07 – 10/13/07, and a note from [redacted] CNA, dated 11/14/07
D-3 Denial Notice from WVMI dated October 18, 2007
*D-4 42 CFR §483.20 Code of Federal Regulations

* Indicates evidence was received subsequent to the hearing.

VII. FINDINGS OF FACT:

1) On or about October 18, 2007, the Claimant was notified that her Medicaid Long-Term Care benefits were denied (Exhibit D-3). This notice states:

> 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 0 areas identified below.

2) Representatives appearing on behalf of the Claimant indicated that the Claimant's appeal is based on two areas of contention – (1) The Claimant contends that policy fails to demonstrate that a new PAS (medical assessment) should have been completed, thereby making the medical eligibility determination moot, and (2), that she remains medically eligible to participate in the Medicaid Long-Term Care program.

3) Representatives from [redacted] Health Care Center [redacted] reported that they recently received training from the Department's Bureau for Medical Services (BMS) regarding continued medical eligibility for nursing facility services and when a reevaluation is necessary. In this case, it was determined that a reevaluation was necessary because the last medical assessment completed in 2005 did not have section #38 completed and the Claimant has had a significant change in her medical condition. It was noted that the Claimant was originally admitted to the facility 2 ½ years ago when a broken ankle was surgically repaired.

4) The Department noted that Medicaid regulations require nursing facility residents must be periodically assessed to determine continued eligibility. Because the Department cited Office of Health Facility Licensure And Certification (OHFLAC) regulations during the hearing, the record remained open for a period of five (5) days to submit supporting regulatory requirements. Although the regulations provided by the Department are not OHFLAC policy, the Federal Regulations provided by the Department govern the Medicaid Long-Term Care Program and are relevant to the Department's position that medical redeterminations are required (Exhibit D-4).

5) The Department cited Medicaid regulations and presented testimony to explain how Medicaid policy was applied to the medical findings documented on the Claimant's PAS. According to the Department's witness, the Claimant's physician completed the medical assessment (Exhibit D-2) and his documentation was relied upon by WVMI to identify qualifying deficits. The Department noted that the Claimant's medical assessment completed on October 16, 2007 (Exhibit D-2) failed to identify any qualifying deficits and therefore demonstrates that she no longer qualifies for nursing facility level of care.

6) The Claimant's representatives contend that the Claimant should have been awarded a deficit in vacating, medication administration and incontinence. It should be noted that the areas of bathing, dressing and walking were introduced as potential areas of contention, however, all parties agreed that these deficits (bathing, dressing and walking) have only recently developed and were not deficits in October 2007.

Vacating - [redacted] _____ contends that the Claimant would not be able to vacate in the event of an emergency due to anxiety. However, testimony received at the hearing reveals that [redacted] conducted a disaster drill (approximately 2-3 months ago) and the Claimant was able to evacuate to the dining room during this drill with supervision. RN [redacted] indicated that documentation on the PAS with regard to vacating (with supervision) is accurate, however, she could not predict if the Claimant would be able to vacate from a home-based setting.

The Claimant was evaluated at a level-1 in orientation (oriented), she had capacity (see Physician's Determination of Capacity in Exhibit D-2a) at the time of the medical assessment, she demonstrated the ability to evacuate during a disaster drill, and she was determined to be ambulatory - Transferring Level-1 (Independent) and Walking Level-2 (Supervised/Assistive Device). The evidence demonstrates that the Claimant was correctly assessed as requiring "supervision" when vacating. Therefore a deficit in vacating cannot be awarded.

Incontinence - The Claimant's representatives purported that the Claimant is a private person and this resulted in an inaccurate evaluation of incontinence. [redacted] _____ testified that when she alerted [redacted] that the Claimant was hiding episodes of incontinence, [redacted] employees found adult diapers hidden in her trash twice over a two-week period.

The Department cited Exhibit D-2a (October 2007 Monthly ADL Flowsheet) that documents urinary and bowel function during the month of October. The Department noted that a "C" for "Continent" was documented in all three shifts (night, day & evening) every day in October 2007. The Department further noted that incontinence is only considered a deficit if the individual experiences three (3) or more episodes per week. If the Claimant was found to have one episode per week, as noted in testimony, this would qualify as occasional incontinence (level 2) and would not qualify as a deficit. Based on the evidence, the Claimant cannot be awarded a deficit based on incontinence.

Medication Administration - Testimony presented at the hearing indicates that the Claimant was wearing a "pain patch" when the assessment was completed and that she was unable to place the patch (as required) on her back. The Department noted that the pain patch medication was not listed on the PAS assessment and that this type of medication therapy is typically a temporary treatment option. Although [redacted] testified that the Claimant was receiving pain patch medication therapy at the time of the assessment, and that the Claimant could not self-administer, there is no clinical evidence submitted to corroborate this claim (medication should be listed on the PAS). While the Claimant may have been receiving medication therapy that she was unable to self-administer, there is insufficient evidence to award a deficit in the area of medication administration.

7) WV DHHR Medicaid, 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. 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 Medicare 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.

A disclaimer located on the bottom of every page in the Medicaid manual states – "*This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations."*

8) Regulations found at 42 CFR 483.20 (Resident assessment) state:

> The **facility** must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.
>
> (a) Admission orders. At the time each resident is admitted, the **facility** must have physician orders for the resident's immediate care.
>
> (b) Comprehensive assessments--(1) Resident assessment instrument. A **facility** must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
>
> (i) Identification and demographic information.
> (ii) Customary routine.
> (iii) Cognitive patterns.
> (iv) Communication.
> (v) Vision.
> (vi) Mood and behavior patterns.
> (vii) Psychosocial well-being.
> (viii) Physical functioning and structural problems.
> (ix) Continence.
> (x) Disease diagnoses and health conditions.
> (xi) Dental and nutritional status.
> (xii) Skin condition.
> (xiii) Activity pursuit.
> (xiv) Medications.
> (xv) Special treatments and procedures.
> (xvi) Discharge potential.
> (xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.
> (xviii) Documentation of participation in assessment.
>
> The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

(2) When required. Subject to the timeframes prescribed in Sec. 413.343(b) of this chapter, a **facility** must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section. The timeframes prescribed in Sec. 413.343(b) of this chapter do not apply to CAHs.

(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the **facility** following a temporary absence for hospitalization or for therapeutic leave.)

(ii) Within 14 calendar days after the **facility** determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

(iii) Not less often than once every 12 months.

(c) Quarterly review assessment. A **facility** must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.

9) West Virginia Income Maintenance Manual Chapter 17.11, B, 1 - ESTABLISHING MEDICAL NECESSITY, THE PAS-2000, (When the PAS is completed):

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.

NOTE: There is no requirement that the name of the facility in which the individual resides appear on the PAS-2000.

NOTE: The date the PAS-2000 is completed for the purpose of establishing medical necessity is the date the physician signs the form, not the date of any other determination made using the PAS-2000.

The PAS-2000 is completed when:

- The individual enters a Medicaid certified facility.

- The individual transfers from one facility to another. Each facility, i.e., building, must have an original approved PAS-2000 even when the client moves from one facility to another governed by the same corporation, and even when 60 days has not passed since the completion of the PAS-2000 for the first facility.

- The individual is admitted to an acute care facility and returns to the same facility, after 60 days.

- The individual's condition changes to the extent that he no longer requires nursing facility services.

VIII. CONCLUSIONS OF LAW:

1) To qualify medically for the Medicaid Long-Term Care services, policy states 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 regulations further state that as a condition of continued eligibility for participation in the Medicaid Long-Term Care program, periodical medical assessments must be completed. Among the reasons for which a medical assessment must be completed is when there has been a significant change in the resident's physical or mental condition –"a major decline or improvement in the resident's status." Although it was noted that the Department's Medicaid policy does not specifically list improvement as a reason for completing a PAS, the disclaimer noted at the bottom of the Medicaid manual states that it must be supplemented with all State and Federal Laws and Regulations. The Code of Federal Regulations requires a medical assessment when "significant" improvement is noted and the West Virginia Income Maintenance Manual states that the PAS is used in that circumstance. The reason for which the PAS was initiated - significant improvement - is both valid and consistent with existing regulatory requirements.

3) The October 16, 2007 PAS reveals that the Claimant demonstrated (0) zero program qualifying deficits.

4) The evidence submitted at the hearing fails to identify any additional program qualifying deficits.

5) Although it was noted that the Claimant's medical condition has deteriorated, the evidence demonstrates that the Claimant presented (0) zero qualifying deficits when the October 16, 2007 medical assessment was completed. As a result, the Claimant is no longer medically eligible to participate in the Medicaid Long-Term Care program.

IX. DECISION:

It is the decision of the State Hearing Officer to **uphold** the proposal of the Department to terminate the Claimant's 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 17th Day of March, 2008.

_____

Thomas E. Arnett
State Hearing Officer