**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

WVDHHR – _____ for
_____
_____
_____

Dear Mr. _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held March 11, 2008. Your hearing request was based on the Department of Health and Human Resources' proposal to terminate your 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 reveals that your medical condition continues to 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 Hearing Officer to **reverse** 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]

**WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES**
**BOARD OF REVIEW**

**_____,**

**Claimant,**

**v.** **Action Number: 07-BOR-2724**

**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 11, 2008 on a timely appeal filed November 28, 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:

Michelle Angus, APSW, DHHR
_____, [redacted]
_____, Intern (observing)
Nora McQuain, RN, BMS (Participated Telephonically)
Stephanie Schieffer, 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 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, 508, 508.1 and 508.2

## VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

**Department's Exhibits**:

| | |
|---|---|
| Exhibit 1 | West Virginia Medicaid (WV Provider Manual) Policy Manual, 508, 508.1 and 508.2 (Medicaid, Long-Term Care) |
| Exhibit 2 | Pre-Admission Screening (PAS) dated 11/13/07 |
| Exhibit 3 | Co. – MDS ADL Report for 10/1/07 through 10/29/07 |
| Exhibit 4 | Nurses Notes beginning 11/13/07 through 11/27/07 |
| Exhibit 5 | Notice of Denial dated 11/14/07 |

Claimant's Exhibits:

| | |
|---|---|
| C-1 | Self-Medication Assessment Form (SMAT) dated 10/6/07 |

## VII. FINDINGS OF FACT:

1) On or about November 14, 2007, the Claimant was notified that his Medicaid Long-Term Care benefits were denied (Exhibit 5). This notice states, in pertinent part:

> 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) 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 completed on November 14, 2007 (Exhibit 2). According to the Department's witness, the Claimant's physician completed the medical assessment and his documentation was relied upon by WVMI to identify qualifying deficits. The Department noted that the Claimant's medical assessment identified only three (3) qualifying deficits, and as a result, he is no longer eligible for a nursing facility level of care.

3) Representatives appearing on behalf of the Claimant contend that the Claimant remains medically eligible to participate in the Medicaid Long-Term Care program as he should have been awarded a deficit in *medication administration*

4) The Claimant's representatives submitted Exhibit C-1, Self-Medication Assessment Form (SMAT), to show that the Claimant has been determined mentally unable to self administer his medications. In addition to his cognitive disability, the Claimant suffers from a tic disorder as well as a seizure disorder. It should be noted that both of these conditions are noted on the PAS (Exhibit 2). The evidence submitted at the hearing clearly demonstrates the Claimant's PAS was marked incorrectly and he is therefore awarded a deficit in *medication administration.*

5) [redacted] testified that because the Claimant had fallen several times around the time the PAS was completed, a wheelchair and bed alarm was put in place. The MDS ADL Report (Exhibit D-3) revels that in the month of October 2007, the Claimant required "limited assistance" on four (4) occasions and supervision on one (1) occasion. The term "limited assistance" was not defined at the hearing, but it the absence of a definition, it will be interpreted as requiring a one person assist as it clearly exceeds supervision. It is reasonable to conclude that the Claimant would have fallen, or was at least determined to be at risk of falling on the days noted. While the Claimant does not appear to require physical assistance with transferring on a daily basis, there are four (4) documented incidents where physical assistance was required. Based on the evidence, the Claimant requires level 3, one person assist, in *transferring* and therefore qualifies for a deficit.

6) 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.

## 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 October 13, 2007 PAS reveals that the Claimant demonstrated three (3) program qualifying deficits.

3) The evidence submitted at the hearing confirms two (2) additional program qualifying deficits in the area of medication administration and transferring.

4) Whereas the Claimant demonstrates five (5) qualifying deficits, the Claimant continues to be medically eligible for participation in the Medicaid Long-Term Care program.

## IX. DECISION:

It is the decision of the State Hearing Officer to **reverse** the Department's proposal 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**