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

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_____
_____

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 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
_____, [redacted]

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

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Claimant,

v. **Action Number: 07-BOR-2731**

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 Wilbert Lewis_____ 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 October 26, 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:

[redacted] Ombudsman
_____, [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 10/2/07
Exhibit 3	Notice of Denial dated 10/12/07
Exhibit 4	Nurses Notes for period 9/4/07 through 10/08/07
Exhibit 5	MDS rating (date of rating unknown)
Exhibit 6	Co. – MDS ADL Report (9/1/07 through 10/6/07)

VII. FINDINGS OF FACT:

1) On or about October 12, 2007, the Claimant was notified that his Medicaid Long-Term Care benefits were denied (Exhibit 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 4 areas identified below – bathing, grooming, dressing, and administering medications.

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 October 2, 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 four (4) qualifying deficits, and as a result, she is no longer eligible for a nursing facility level of care.

3) The Claimant's brother and Medical Power of Attorney (MPOA), [redacted] was contacted by phone for the hearing. The MPOA indicated he did not wish to participate in the hearing and authorized [redacted] Ombudsman, to represent the Claimant.

4) 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 *transferring* and he is unable to *vacate in the event of an emergency*.

5) The Claimant's representatives contend that the documentation regarding transferring is incorrect. reported that there has been a physician's order in place since February 14, 2007 for a RFA alarm on his bed and wheelchair at all times because the Claimant has been determined a risk for falls when he attempts to transfer independently. She indicated his difficulty in transferring is related to breathing difficulties, poor safety awareness and intermittent edema to his lower extremities. The Claimant is also receiving physical therapy due to weakness in his upper extremities. He is resistant to physician's orders to stay in bed and elevate his legs, so his edema gets worse and affects his ability to walk. [redacted] testified that she is not sure why transferring was not marked, at a minimum, supervised / assistive device (level 2) or one person assist (level 3).

The Department cited Exhibit 4 (Nurses Notes) on September 5, 2007 and noted they do not include any information regarding transferring difficulties. Exhibit 4 does indicate – "balance is unsteady when standing, however resident does ambulate for short distances using either a walker or behind wheelchair." Documentation in Exhibit 5 fails to identify any difficulty with transferring and the Co. – MDS ADL Report for the month of September 2007 (Exhibit 6) indicates the Claimant was independent with transferring the entire month, requiring supervision on only one occasion - September 7, 2007.

The clinical documentation fails to demonstrate that the PAS completed on October 2, 2007 is incorrect. Based on the evidence, the Claimant is not demonstrating a deficit in transferring.

6) With regard to vacating, the Claimant reportedly has difficulty with hearing. This condition, in conjunction with his upper body weakness, according to his representatives, could cause times when he would be unable to vacate the building in the event of an emergency. This conclusion, however, is not supported by the evidence as Exhibit 4 (Nurses Notes dated 9/5/07) states – "His primary mode of transportation is wheelchair. He propels wheelchair independently." Additionally, the PAS evaluation (Exhibit 2) indicates that the Claimant's hearing is level 1 (not impaired). The evidence fails to support the determination that the Claimant is demonstrating a program qualifying deficit in vacating.

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.

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 2, 2007 PAS reveals that the Claimant demonstrated four (4) program qualifying deficits - bathing, grooming, dressing, and administering medications.

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

5) Whereas the Claimant demonstrates only four (4) qualifying deficits, the Claimant's medical eligibility for participation in the Medicaid Long-Term Care program cannot be established.

IX. DECISION:

It is the decision of the State Hearing Officer to **uphold** 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.

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Thomas E. Arnett
State Hearing Officer