



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 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
_____, Ombudsman
_____, _____

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

_____ ,

Claimant,

v.

Action Number: 07-BOR-2738

**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 October 30, 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:

- _____ Ombudsman
- _____ , Claimant's Son / POA
- _____ , Claimant's Grandson
- _____ , _____
- _____ , Claimant's Daughter-in-law (observing)
- _____ , Granddaughter-in-law (observing)

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 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 2a	Progress Notes (9/16/07 to 9/17/07)
Exhibit 2b	Nurses Notes (9/24/07 – 9/26/07)
Exhibit 2c	Progress Notes (9/29/07 to 9/30/07)
Exhibit 2d	MDS – Date of rating unknown
Exhibit 2e	CO. – MDS ADL Report - dated 11/8/07 (pages 16, 17 & 19)
Exhibit 3	Denial Notice from WVMI dated October 18, 2007

VII. FINDINGS OF FACT:

- 1) On or about October 23, 2007, the Claimant, through her representative, was notified that her 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) Representatives appearing on behalf of the Claimant contend that the Claimant remains medically eligible to participate in the Medicaid Long-Term Care program as she should have been awarded a deficit in *incontinence* (bladder) and she is unable to *vacate* in the event of an emergency.
- 4) The Claimant's representatives purported that the documentation regarding *incontinence* is inaccurate. _____ testified the Claimant's medical record reflects a diagnosis of urinary incontinence (unspecified) and a history of urinary tract infections. While Exhibit 2b notes the Claimant was being treated for a UTI, the diagnosis of urinary incontinence does not appear on the PAS and Exhibits 2a, 2b, 2d and 2e includes documentation indicating the Claimant is continent of bladder. Based on the clinical evidence, the Claimant cannot be awarded a deficit in incontinence.
- 5) The Claimant's representatives contend the Claimant is both physically and mentally unable to vacate the building in the event of an emergency. In support of this argument, the Claimant was noted to present a diagnosis of Organic Brain Syndrome and Psychosis as well as Alzheimer's. According to testimony presented at the hearing, the Claimant could be directed to an exit less than five feet away and she would still be unable to find the door. The Claimant's mental limitations are further demonstrated by the fact that she has been found incapacitated. In addition to the complications caused by the Claimant's mental diagnoses, the Claimant's mobility is slow and deliberate under normal circumstances with the use of a walker, however, it was noted that due to being inflicted with Polio at a young age, the Claimant cannot ambulate without shoes. Should an emergency develop that would require a hasty exit in the middle of the night, the Claimant would require physical assistance.

Based on the evidence, the PAS evaluation (Exhibit 2) is inaccurate and the Claimant demonstrates a deficit in *vacating* the building in the event of an emergency.

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 2, 2007 PAS reveals that the Claimant demonstrated four (4) program qualifying deficits.
- 4) The evidence submitted at the hearing identifies one (1) additional program qualifying deficit in the area of vacating in the event of an emergency.
- 5) 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**