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

August 28, 2008

_____, Esq.
Elder Law Attorney for
_____
_____
_____

Dear Mr. _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held July 31, 2008. Your hearing request was based on the Department of Health and Human Resources' action to deny 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 the hearing reveals that your client's medical condition in February 2008 required the degree of care necessary to qualify her for Medicaid Long-Term Care benefits.

It is the decision of the State Hearing Officer to **reverse** the Department's action to deny your client's 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
Mary McQuain, Esq., Assistant AG's Office

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

_____,

Claimant,

v. **Action Number: 08-BOR-993**

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 August 28, 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 convened July 31, 2008 on a timely appeal filed February 26, 2008.

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:

_____, Esq., Counsel for the Claimant
_____, Claimant's Brother / Attorney-in-fact
_____, Claimant's Sister-in-law
[redacted] RN, [redacted] Health Care Center
[redacted] LSW, [redacted] e Health Care Center
[redacted] Administrator, [redacted] Health Care Center

The Department's representative and witnesses participated telephonically
Mary McQuain, Esq, Assistant AG's Office, Counsel for the Department
Nora McQuain, RN, BMS
Kelley Johnson, MSW, BMS (observed)
Stacy Holstine, RN, WVMI

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 the Board of Review has jurisdiction to preside in this matter and (2) whether the Claimant met medical eligibility criteria for participation in the Medicaid Long-Term Care (Nursing Facility) Program in February 2008.

V. APPLICABLE POLICY:

West Virginia Medicaid Manual, 508, 508.1 and 508.2

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

Exhibit-1	Pre-Admission Screening (PAS) dated 2/8/08
Exhibit-2	Denial Notice from WVMI dated 2/13/08
Exhibit-3	Request for Hearing received 2/26/08
Exhibit-4	West Virginia Medicaid (WV Provider Manual) Policy Manual, 508, 508.1 and 508.2 (Medicaid, Long-Term Care)
Exhibit-5a	Minimum Data Set (MDS
Exhibit-5b	Monthly ADL Flowsheets for January & February 2008
Exhibit-5c	Nurse's Notes for period 1/30/08 to 2/14/08

Claimant/Petitioner's Exhibits

Claimant's Exhibit-1 Physician's Statement, Notarized on May 16, 2008.

VII. FINDINGS OF FACT:

1) On or about February 13, 2008, the Claimant was notified that her application for Medicaid Long-Term Care benefits was denied (Exhibit 2). 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 4 areas identified below – bathing, grooming, dressing, and walking.

This notice goes on to state-

> **REQUEST FOR HEARING:** If you do not agree with this decision, and wish to appeal to a State Hearing Officer, you must request a Hearing within 90 days of the date of this letter. A form to request a Hearing is enclosed. If you need transportation to the hearing or if you need special accommodations, please check the appropriate box.
>
> **HEARING AND WITNESSES:** At this hearing, you have a right to ask questions regarding the evaluation. You may bring any other witnesses to testify on your behalf, and to present evidence of your condition at the time of the evaluation {Emphasis added}.

2) A new medical assessment was subsequently completed and eligibility for participation in the Medicaid Long-Term Care Program was established effective April 1, 2008. There are, however, two months of nursing facility services (February & March 2008) for which payment has not been made to the nursing facility. The issue surrounding this appeal is two fold:

(a) The Claimant contends that she was medically eligible for Medicaid benefits effective February 2008 but for an administrative/documentation error by the evaluating physician. Claimant's Exhibit 1 was submitted in support of the Claimant's appeal.

(b) The Department objected to Claimant's Exhibit 1 being entered into evidence as policy does not provide for amendments to the PAS. The Department further contends that this is a provider appeal for which the Bureau of Medical Services (BMS) has an appeal mechanism in place and that the Board of Review does not have the authority to back-date Medicaid coverage and/or require BMS to pay Medicaid benefits for February and March 2008 based on Medicaid policy found in Vol. 15 §508.

The Claimant's financial eligibility as of February 1, 2008 was uncontested.

3) The Department contention that the Board of Review does not have jurisdiction in this matter is based on the WV Medicaid Policy Manual, Vol. 15 §508:

> The Department has established a process of evaluation to determine eligibility for long term care services under the Medicaid Program. The evaluation is made on each recipient from information supplied by a physician, recipient or family/representative, health care facility and/or eligibility worker in the local Department of Health and Human Resources office. This determination for the Medicaid benefit for nursing facility residents is based on both medical and financial criteria. The Bureau for Medical Services or its designee is responsible for the medical necessity determination and the Bureau of Children and Families is responsible for the financial determination.
>
> The determination must occur prior to payment for services. The date the benefit starts is the later of one of the following dates:
>
> - The date of application in the local DHHR office;
> - The date of the physician signature on the medical assessment tool; or the date of admission to the nursing facility.
>
> The local office is responsible for notifying the individual/representative, the Bureau and the nursing facility of the date Medicaid eligibility begins.

4) Provisions in the notice clearly indicate that the Claimant has the right to appeal the adverse medical finding to the State Hearing Officer and to present evidence regarding her condition at the time the evaluation was completed. The Department's renewed motion to dismiss the Claimant's appeal, taken under advisement at the hearing, is therefore denied.

5) 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 [emphasis added]. 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.

6) The evidence indicates that the Claimant was private pay and not Medicaid eligible when admitted to the [redacted] Health Care facility.

7) The Department's objection to the admittance of the physician's sworn statement (Claimant's Exhibit 1) into evidence was taken under advisement, however, upon consideration, this document is recognized as a medical form because its purpose is an acknowledgement that the physician made an error on the PAS. While the Department argued that there are no provisions in policy to allow an amendment to a PAS, this document will be considered in conjunction with the medical evidence reviewed to determine if the Claimant demonstrated a fifth (5^{th}) program qualifying deficit in vacating the building in the event of an emergency.

8) A review of the medical evidence provides the following findings:

Claimant's Exhibit 1 is a sworn statement signed by [redacted]mitt, M. D. In this statement, Dr. [redacted] states – "Because of accidental clerical mis-marking that PAS-2000, it did not accurately reflect my medical opinion of Ms. _____'s deficits. Specifically, Question 25 of the February 8, 2008, PAS-2000 erroneously stated that in the event of an emergency, Ms. _____ could vacate the building with supervision, whereas, the correct answer at that time would have been that Ms. _____ was physically unable to vacate the building. Had the February 8, 2008, PAS accurately reflected my professional opinion of Ms. _____'s deficit regarding Question 25, she would have had five (5) deficits and, accordingly, would have and should have been medically eligible for Nursing Home Medicaid."

Department's Exhibit-1, PAS-2000 completed on February 8, 2008, indicates that the Claimant was assessed at a level 3 (one person physical assistance) in walking.

Exhibit 5a is the Claimant's Minimum Data Set (MDS) – Version 2.0 is undated but contains signatures in November 2007. This document provides the following in Section G - Physical Functioning and Structural problems:
TRANSFER – Level 1 (Supervision - oversight, encouragement or cueing provided 3 or more times during last 7 days – or – Supervision 3 or more times plus physical assistance provided only 1 or 2 times during last 7 days.)
WALK IN ROOM – Level 2 (Limited Assistance – Residence highly involved in activity; received physical help in guided maneuvering of limbs or their nonweight bearing assistance 3 or more times – OR – More help provided only 1 or 2 times during last 7 days.)
WALK IN CORRIDOR – Level 2 (see level 2 above)
LOCOMOTION ON UNIT – Level 1 (see level 1 above)
LOCOMOTION OFF UNIT – Level 1 (see level 1 above)

It is unclear why the Claimant requires limited assistance in her room and corridor but only supervision while on/off the unit.

Exhibit 5b (Monthly ADL Flowsheet) fails to address ambulation and/or vacating the building on the front page, however, a note attached to the back dated February 1, 2008 states – "Resident gets up and takes herself to bathroom. She won't put her light on for help." A note dated February 4, 2008 states – "resident is weight bearing."

Exhibit 5c includes Nurse's Notes for the period January 30, 2008 through February 14, 2008. - The weekly note on January 31, 2008 indicates that the Claimant requires assist of one with ADL's, Transfers. While the Department's witness indicated this note fails to address the Claimant's ability to vacate, the Claimant's ability to transfer, although not identified on the PAS as a deficit, clearly affects vacating abilities in the event of an emergency.

- Weekly note dated February 5, 2008 states – "Ambulates self to BR [bathroom]." This note goes on to say – "Educated several X's [times] on ringing call light."

The preponderance of evidence confirms that the Claimant demonstrates difficulty with transferring (documented hands-on assistance required in the nursing notes) and requires hands-on physical assistance with walking. The PAS indicates level 3 (physical assistance) in walking and it is noted that the Claimant has been trained and encouraged to use her call light, presumably for her own safety, but fails to recognize the safety concerns due to her confusion. Documentation found in the MDS further confirms that she requires some assistance ambulating in the nursing facility. When these factors are considered in conjunction with the physician's sworn statement, the Claimant is physically unable to vacate the building in the event of an emergency.

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) Medical eligibility for each recipient is determined from information supplied by a physician, recipient or family/representative, health care facility and/or eligibility worker in the local Department of Health and Human Resources office. The determination for the Medicaid benefit for nursing facility residents is based on both medical and financial criteria. The Bureau for Medical Services or its designee is responsible for the medical necessity determination. 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. 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.

3) Policy refers only to admitting a "Medicaid eligible individual" without an approved PAS when stating the individual cannot be charged for the cost of care during the non-covered period. The Claimant was private pay - and not Medicaid eligible - when she was admitted to the nursing facility in 2007. Therefore, policy, as it is written, did not apply to the Claimant at the time of her February 2008 application. In the absence of evidence to the contrary, the Claimant would be responsible for payment of services during the non-covered period.

4) Based on basic due process rights and the language included in the February 13, 2008 denial notice from WVMI, the Claimant exercised her right to request a hearing and present evidence of her condition at the time of the evaluation. It is necessary for a Hearing Officer to be able to make a finding on any matter under appeal – including physician certification – based on credible testimony and evidence. The Claimant's medical eligibility is not being reviewed for the purpose of backdating Medicaid, but rather to determine her condition at the time of the evaluation.

5) The evidence reveals that the Claimant was awarded four (4) deficits resulting from the February 2008 PAS. Documentation submitted during the hearing demonstrates that the Claimant, at the time of the assessment, was physically unable to vacate the building in the event of an emergency. Therefore, one additional deficit is awarded.

6) Whereas the Claimant demonstrates five (5) qualifying deficits, eligible for participation in the Medicaid Long-Term Care program is approved effective February 1, 2008.

IX. DECISION:

It is the decision of the State Hearing Officer to **reverse** the Department's action to deny the Claimant's application for Medicaid Long-Term Care (Nursing Facility) benefits in February 2008.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 28th Day of August, 2008.

_____

Thomas E. Arnett
State Hearing Officer