State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
203 East Third Avenue
Williamson, WV 25661

Earl Ray Tomblin
Governor

Michael J. Lewis, M.D., Ph.D.
Cabinet Secretary

August 26, 2011

-----For: -----

Dear -----:

Attached is a copy of the findings of fact and conclusions of law on your hearing held on July 14, 2011. Your hearing request was based on the Department of Health and Human Resources' denial of Long Term Care Medicaid admission based on medical ineligibility.

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.

The determination of medical eligibility for Long Term Care Medicaid is based on current policy and regulations. These regulations state that to qualify medically for the nursing facility Medicaid benefit, an individual must need full-time direct nursing care. 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 Medicaid applicants. An individual must have a minimum of five deficits identified on the PAS in order to qualify for the Medicaid nursing facility benefit. (Nursing Facility Services Provider Manual Chapter 514)

The information submitted at your hearing revealed that the Department was not correct in its assessment of one deficit and was not correct in its determination of medical ineligibility for the program.

It is the decision of the State Hearing Officer to **reverse** the Department's denial of Long Term Care Medicaid based on unmet medical eligibility.

Sincerely,

Stephen M. Baisden
State Hearing Officer
Member, State Board of Review

cc: Erika Young, Chairman, Board of Review
Amy Workman, Bureau of Medical Services
[redacted] Nursing and Rehabilitation Center, [redacted] WV

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

-----,
Claimant,

v. **Action Number: 11-BOR-1238**

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 26, 2011 for -----. The DHHR Board of Review held this hearing in accordance with the provisions found in the Common Chapters Manual, Chapter 700 of the West Virginia Department of Health and Human Resources. The Board of Review convened this fair hearing on July 14, 2011 on a timely appeal, filed May 19, 2011.

II. PROGRAM PURPOSE:

The program entitled Long Term Care Medicaid (nursing facility services) is a medical service that is covered by the State's Medicaid Program. Payment for care is made to nursing homes that meet Title XIX (Medicaid) standards for the care provided to eligible recipients. In order to qualify for Nursing Home Care, an individual must meet financial and medical eligibility criteria.

III. PARTICIPANTS:

-----, Claimant's Daughter and Representative
-----, Claimant's Brother and Witness
-----, Claimant's Sister-In-Law and Witness
-----, Claimant's Son-In-Law and Witness

Kelley Johnson, WV Bureau of Medical Services, Department's Representative
Karen Keaton, RN, WV Medical Institute (WVMI), Department's Witness

Presiding at the Hearing was Stephen M. Baisden, State Hearing Officer and a member of the State Board of Review.

The hearing was conducted via telephone conference call.

The hearing officer placed all participants under oath at the beginning of the hearing.

IV. QUESTION TO BE DECIDED:

The question to be decided is whether the Department is correct in its determination that the Claimant is medically ineligible for Long Term Care Medicaid.

V. APPLICABLE POLICY:

Nursing Facility Services Provider Manual, Chapter 514; §514.8; §514.8.1; §514.8.2

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 Nursing Facility Services Provider Manual, Chapter 514; §514.8; §514.8.1; §514.8.2
D-2 Pre-Admission Screening (PAS) dated April 27, 2011
D-3 Notice of Denial Determination dated April 29, 2011
D-4 Nursing notes from [redacted] Nursing and Rehabilitation Center

VII. FINDINGS OF FACT:

1) Claimant is an 80-year old male, currently residing in [redacted] Nursing and Rehabilitation Center in [redacted] WV. Medical staff at [redacted] Nursing and Rehabilitation completed a Pre-Admission Screening (PAS) form on April 27, 2011 (Exhibit D-2) to assess the Claimant's medical eligibility for the WV Medicaid Long-Term Care program.

2) Department's representative testified that the Nursing Facility Services Provider Manual, Chapter 514, contains the applicable policy pertaining to medical eligibility for Long Term Care Medicaid. From this chapter, §514.8 (Exhibit D-1) states, in pertinent part:

> **514.8.1 APPLICATION PROCEDURE**
> An application for nursing facility benefits may be requested by the resident, the family/representative, the physician, or a health care facility. The steps involved in approval for payment of nursing facility services are:
>
> - The application for NF service is made to the local DHHR office. The determination of financial eligibility for Medicaid is the responsibility of the local office; and

- The medical eligibility determination is the responsibility of the Bureau for Medical Services based on a physician's assessment of the medical and physical needs of the individual. This assessment must have a physician's signature dated not more than sixty days prior to the start of services.

514.8.2 MEDICAL ELIGIBILITY

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.

. . .

A new medical assessment must be done for Medicaid eligibility for the nursing facility resident for all of the following situations:

- Application for the nursing home benefit;
- Transfer from one nursing facility to another;
- Previous resident returning from any other than an acute care hospital;
- Resident transferred to an acute care hospital, then to a distinct skilled nursing unit, then returns to the original nursing facility; and
- Resident converts from private pay to Medicaid.

3) Department's witness, a registered nurse with West Virginia Medical Institute (WVMI), testified that the Claimant had deficits in one area, *administering medications*.

4) The Department issued a Notice of Denial Determination (Exhibit D-3) to the Claimant on or about June 15, 2009. The notice states, in pertinent part:

> **NOTICE:** YOUR REQUEST FOR LONG-TERM CARE (NURSING HOME) ADMISSION HAS BEEN DENIED.
>
> 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.

5) Claimant's representative testified that on the April 27, 2011, PAS (Exhibit D-2), her father should have received deficits in a number of areas. These are as follows:

> ***Vacating a building during an emergency*** – The PAS indicated that Claimant could vacate a building during an emergency with supervision. Claimant's representative testified that her father's disorientation and his limited mobility prevented him from doing this. Claimant's witness stated that Claimant could not find his way from the hallway of his nursing home residence to his room if he were any more than two doors away.
>
> ***Bathing*** – Department's representative conceded that Claimant should have received a deficit for this functional ability.
>
> ***Dressing*** – Claimant's representative and witnesses testified that on several occasions, nursing staff at Boone Nursing and Rehabilitation had asked them to step out of Claimant's room while they helped him dress. One of Claimant's witnesses testified he had observed during visits with Claimant that Claimant was wearing three shirts and two pairs of pants,

or two shirts and three pairs of pants. Department's representative testified that the purpose of the PAS was to assess Claimant's ability to dress himself, to fasten buttons, snaps and zippers, not to address whether or not Claimant dressed appropriately.

Continence – Claimant's representative testified that she had to buy adult diapers for her father because he had urinary accidents. Department's representative testified that the occasional urinary accident is not sufficient to assess an applicant with a deficit for incontinence, and that he would have to have accidents several times per week.

Orientation – Claimant's representative and witnesses testified that Claimant is disoriented and often forgets where he is. A witness for Claimant testified that he arrived for a visit at Boone Nursing and Rehabilitation, and found Claimant in his wheelchair at the facility's reception desk. He stated that even though the desk was only a few doors away from Claimant's room, Claimant did not know where his room was. Department's representative testified that in order to receive a deficit for orientation, Claimant would have to be disoriented at all times. She stated that his intermittent disorientation was not enough to justify assessing him with a deficit for this functional ability.

Walking – Claimant's representative stated that her father could not walk more than a few steps, and he had to use a walker when he did. Claimant's witness stated that he does not walk down the hallway at his nursing facility, he only walks from his bed to the bathroom while in his room, and when he does, he holds onto his bed or the wall of his room. Department's representative testified that in order to receive a deficit for walking, Claimant had to have someone holding him or steadying him at all times as he walked.

6) The Department submitted as evidence nursing notes written by [redacted] Nursing and Rehabilitation staff from March 26 to May 2, 2001. (Exhibit D-4.) These notes provide some insight into Claimant's condition at the time of the April 27, 2011 PAS. These notes indicate as follows:

Dressing – Nursing notes from April 23, 2011 and April 9, 2011, indicate that Claimant dresses himself "with assist from staff as needed."

Continence – A nursing note from April 23, 2011, states, "Toilets self with occasional incontinence." A note from April 16, 2011, states, "[Claimant] is continent with bowel and bladder, staff does provide pericare when needed." A note from March 26, 2011, states, "Continent of bowel and bladder functions."

Orientation – A nursing note from April 16, 2011, states, "[Claimant] is confused regarding place, time and situation." A note from April 2, 2011, states, "Resident suffers from a brain injury that causes him to be confused at times." A note from March 28, 2011, states, "Alert and verbal to voice with confusion noted." A note from March 26, 2011, states, "Alert and verbal with confusion noted at times." A second note from that day discusses an abrasion on Claimant's arm. The note states, "This nurse asked [Claimant] what happened and he stated that he was wheeling himself around facility last night and scraped it on the wall."

Walking – A nursing note wherein the date was obscured states, "[Claimant] ambulates ad-lib with slow steady gait." Notes from April 24, April 23, April 16, April 9, April 2, March 27, and March 26, 2011, all mention that staff observed Claimant ambulating through the facility in his wheelchair. A note from April 23, 2011, states, "Ambulates with rolling walker per self at times." A note from April 16, 2011, states, "Claimant can ambulate to the restroom with staff assistance."

VIII. CONCLUSION OF LAW:

1) Medical eligibility for Long Term Care Medicaid requires a minimum of five deficits in functional areas. The Department identified and awarded one deficit on the Claimant's April 27, 2011, PAS, for administering medications. During the hearing, Department's representative conceded that the nursing facility should have assessed a deficit for bathing.

2) Documentation supports the finding that Claimant should have been assessed a deficit for dressing.

3) Documentation does not indicate that Claimant's incontinence is frequent enough to justify awarding a deficit for this functional ability.

4) Documentation does not indicate that Claimant's disorientation is any more than occasional, therefore the Department was correct in not assessing a deficit for this functional ability.

5) Documentation indicates that Claimant was able to walk with a walker or with assistance from staff at times, but most notes indicate staff observed him in his wheelchair. Therefore, since the documentation indicates Claimant was ambulating with his wheelchair more often than not, the Claimant should have been assessed a deficit for this functional ability.

6) Documentation does not directly address Claimant's ability to vacate a building in the event of an emergency. However, Claimant's occasional disorientation and his walking

difficulties limit his ability to vacate in the event of an emergency. Therefore, Claimant should have been assessed a deficit in this area of the PAS.

7) Claimant should have received additional deficits for dressing, walking, and vacating a building in the event of an emergency. Claimant should have received the necessary five deficits on the April 27, 2011, PAS to be eligible for Long-Term Care Medicaid.

IX. DECISION:

It is the decision of the State Hearing Officer to **reverse** the Department's proposed denial of Long Term Care Medicaid based on medical ineligibility.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 26th Day of August, 2011.

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Stephen M. Baisden
State Hearing Officer