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

September 2, 2011

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

Dear -----:

Attached is a copy of the Findings of Fact and Conclusions of Law on your client's hearing held on August 19, 2011. Her 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 correct in its assessment of no deficits and was correct in its determination of medical ineligibility for the program.

It is the decision of the State Hearing Officer to **uphold** 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
Mary McQuain, Esq., WV Bureau for Medical Services
Amy Workman, Bureau of Medical Services

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

-----,

Claimant,

v. **Action Number: 11-BOR-1373**

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 September 2, 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 August 19, 2011 on a timely appeal, filed June 10, 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:

-----, -----, Counsel for Claimant
-----, Claimant
-----, Claimant's Witness

Mary McQuain, Esq., Assistant Attorney General, WV Bureau of Medical Services
Kelley Johnson, WV Bureau of Medical Services, Department's Witness
Jenny Craft, 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 May 19, 2011
D-3 Notice of Denial Determination dated May 19, 2011
D-4 Activities of Daily Living Record Chart from [redacted] Center [redacted] WV, for April 2011 and May 2011
D-5 Progress notes from [redacted] Center, dated April 19 to May 19, 2011
D-6 Resident Assessment and Care Screening from [redacted] Center, dated March 21, 2011
D-7 Care Plan Review from [redacted] Center, dated April 7, 2011
D-8 Physician's Orders from [redacted] Center, dated April 30, 2011
D-9 Physical Examination Notes from [redacted] Services, dated April 11, 2011 and May 9, 2011

VII. FINDINGS OF FACT:

1) Claimant is an 82-year-old female, currently residing in [redacted] Center in [redacted] WV. Medical staff at [redacted] Center completed a Pre-Admission Screening (PAS) form on May 19, 2011 (Exhibit D-2) to assess the Claimant's medical eligibility for the WV Medicaid Long-Term Care program.

2) Counsel for the Department submitted into evidence the Nursing Facility Services Provider Manual, Chapter 514, which 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 on the May 19, 2011 PAS, the Claimant was assessed with a deficit in one area, *bathing*.

4) The Department issued a Notice of Denial Determination (Exhibit D-3) to the Claimant on or about May 11, 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, by counsel, asserted that on the May 19, 2011, PAS (Exhibit D-2), Claimant 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 independently. Claimant, by counsel, argued that her walking and breathing difficulties would prevent her from vacating the facility in the event of an emergency. Claimant testified that approximately three years earlier, at another facility in which she resided, a flooding emergency necessitated evacuation, and facility employees wheeled her out of the building. Claimant also testified that she knew how to get to the emergency exits of her nursing home, and she knew how to operate the security doors out of the building. Counsel for the Department argued that the flooding emergency occurred three years before the PAS was conducted, well before the period of time which the May 19 PAS covers, and there was no documentation in Claimant's nursing facility records to support Claimant's testimony that this incident happened.

Grooming – The Department stipulated that Claimant should have received a deficit for this functional ability.

Walking – The PAS indicated that Claimant was able to walk with assistive devices and assessed her at a level 2. Counsel for the Claimant asserted that Claimant's medical records from her nursing facility clearly document that Claimant cannot walk. Department's witness testified that after reviewing the documentation, she believed a deficit should have been assessed for walking.

Wheeling – The PAS indicated that Claimant was able to wheel herself throughout her nursing facility with supervision, and assessed her at a level 2. Counsel for Claimant asserted that Claimant needs one-person assistance with wheeling because she cannot get her wheelchair through doorways. Claimant testified that she needs help getting her wheelchair through doorways and cannot get her wheelchair close enough to her bed to get from the chair to the bed. Counsel for the Department asserted that in order to receive a deficit for wheeling, Claimant would require one-person assistance, and there was no documentation from the PAS or the nursing home records to support this contention.

Administering Medications – The PAS indicated that Claimant was able to administer her medications, and assessed her with no deficit in this area. Counsel for Claimant cited Exhibit D-8, a list of physician's orders in effect during the time of the PAS, which includeds an order dated June 23, 2010 that reads, "Patient may not administer own meds. Counsel for the Department argued that the documentation did not indicate that Claimant could not administer her medication, and that the note which indicated this was written a year before the PAS was conducted.

VIII. CONCLUSION OF LAW:

1) Medical eligibility for Long Term Care Medicaid requires a minimum of five deficits from a set of functional life areas. The nursing home staff who conducted Claimant's May 19, 2011 PAS identified and assessed one deficit for the Claimant, in the area of *bathing*. During the hearing, Counsel for the Department stipulated that Claimant should have been assessed with a second deficit, for *grooming*.

2) Counsel for the Claimant argued that she also should have received deficits in the areas of *vacating a building during an emergency*, *walking*, *wheeling* and *administering medications*.

3) The nursing facility was correct in not assessing Claimant with a deficit for *vacating a building during an emergency*. There was no documentation to indicate whether or not Claimant could vacate, and she testified that she knew how to get through the facility's security doors.

4) The nursing facility was incorrect in not assessing Claimant with a deficit for *walking*. Department's witness testified that the documentary evidence supports this.

5) The nursing facility was correct in not assessing Claimant with a deficit for *wheeling*. There is no documentation to support the assertion that Claimant needed anything more than supervision to help her with using her wheelchair.

6) The nursing facility was correct in not assessing Claimant with a deficit for *administering medications*. The documentation indicates Claimant "may not" administer her own medications, but it does not address whether or not Claimant has the physical ability to place a pill or tablet into her mouth.

7) In addition to the two deficits listed in item #1 above, Claimant should have received a third deficit, for *walking*. However, based on her May 19, 2011 PAS and documentation from her nursing facility, she does not have enough deficits to meet the medical criteria for the Medicaid Long-Term Care program.

IX. DECISION:

It is the decision of the State Hearing Officer to **uphold** 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 2nd Day of September, 2011.

_____

Stephen M. Baisden
State Hearing Officer