State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
9083 Middletown Mall
White Hall, WV 26554

Earl Ray Tomblin
Governor

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

October 21, 2011

Re: ----- Case No.: 11-BOR-1797

Dear -----:

Attached is a copy of the Findings of Fact and Conclusions of Law on the hearing held October 20, 2011 in the matter of -----. -----appeal was based on the Department of Health and Human Resources' proposal to terminate her benefits through the Medicaid Long-Term Care (Nursing Facility) Program.

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.

Information submitted at the hearing demonstrates that -----medical condition continues to require a sufficient number of services and the degree of care necessary to qualify for nursing facility care.

It is the decision of the State Hearing Officer to **reverse** the Department's proposal to terminate -----benefits through the Medicaid Long-Term Care Program.

Sincerely,

Thomas E. Arnett
State Hearing Officer
Member, State Board of Review

Pc: Erika H. Young, Chairman, Board of Review
Kelley Johnson, LTC Program Manager, BMS
[redacted]Health and Rehabilitation

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

-----,

Claimant,

v. **Action Number: 11-BOR-1797**

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondent.

DECISION OF STATE HEARING OFFICER

I. INTRODUCTION:

This is a report of the State Hearing Officer resulting from a fair hearing concluded on October 21, 2011 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 on October 20, 2011 on a timely on a timely appeal filed August 16, 2011.

II. PROGRAM PURPOSE:

The program entitled Long Term Care Medicaid (nursing facility services) 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 (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 Representative / MPOA / Attorney-In-Fact
Kelley Johnson, Long-Term Care Program Manager, Bureau for Medical Services (BMS)
Kerry Frame, RN, West Virginia Medical Institute (WVMI)

Presiding at the hearing was Thomas E. Arnett, State Hearing Officer and a member of the State Board of Review.

This hearing was conducted via telephone conference call.

IV. QUESTION TO BE DECIDED:

The question to be decided is whether the Department was correct in its proposal to terminate the Claimant's application for Long-Term Care (Nursing Facility) Medicaid benefits due to an unfavorable medical determination.

V. APPLICABLE POLICY:

West Virginia Medicaid Manual, Chapter 500, Section 514

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 WV Medicaid Manual, Chapter 500, Section 514.8.2 (pages 1-3)
D-2 Pre-Admission Screening (PAS) form - dated 6/10/11 (pages 4-9)
D-3 Notice of Denial Determination from WVMI - dated 7/27/11 (page 10)
D-4 Supporting Documentation (pages 11-91)

VII. FINDINGS OF FACT:

1) On July 27, 2011, a Pre-Admission Screening (PAS) form (Exhibit D-2) was forwarded to West Virginia Medical Institute, hereinafter WVMI, by the [redacted] Health and Rehabilitation, so that a determination of medical eligibility for continued participation in the Medicaid Long-Term Care (Nursing Facility) Program could be completed on the Claimant.

2) On or about July 27, 2011, the Claimant was notified that her request for Medicaid Long-Term Care benefits was denied (D-3). 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 West Virginia Medical Institute (WVMI) on the Pre-Screen Admission Screening (PAS) form. It has been determined you are ineligible for long-term care (nursing home) **admission based upon WV Medicaid criteria.**
>
> **<u>REASON FOR DECISION:</u> Eligibility for long-term care placement being funded by West Virginia 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; thus your request for long-term care (nursing home) is being denied. The PAS (Pre-Admission Screening Form), reflected deficiencies that meet the severity criteria in four (4) areas identified below. – Bathing, Grooming, Dressing and Administering Medications.**

3) As a matter of record, and consistent with the information found in D-3, the Department stipulated that the Claimant is demonstrating four (4) functional deficits – bathing, grooming dressing and administering medications. The Department, represented by Kelley Johnson, cited Medicaid regulations and called its witness (Kerry Frame, RN) from WVMI to explain how Medicaid policy was applied to the medical findings documented on the Claimant's July 27, 2011 Pre-Admission Screening Form (PAS).

4) The Claimant, represented by -----[redacted] contends that she is also demonstrating a deficit in vacating [in the event of an emergency]. The evidentiary finding that follows will address the Claimant's functional ability in the contested area:

Vacating – Policy directs that an individual must be physically or mentally unable to vacate [in the event of an emergency] and require hands-on physical assistance in order to qualify for a deficit. The Claimant's representative presented testimony to indicate the Claimant would be unable to vacate due to physical and mental impairments. -----testified that the Claimant has an unsteady gait and often has prolonged periods of dizzy spells. It was reported that the Claimant has had occasions when she was unable to get out of bed for an entire day due to being dizzy. ----further testified that the Claimant has a history of falls, suffers from chronic back pain, and is being treated for anxiety and depression. A review of Exhibit D-2, page 5, confirms that the Claimant is being treated for anxiety/depression and vertigo. Exhibit D-4 includes documentation from the nursing facility's July 5, 2011 Minimum Data Set (MDS) which is used by the facility to assess the Claimant's functional status. A review of the evidence identified as page 31 reveals that walking (in the room, corridor and unit) requires one-person physical assistance and transferring (from bed, chair, to standing position) is noted to require one-person physical assistance. The evidence in this case clearly supports a finding that the Claimant is demonstrating a functional deficit in vacating.

5) WV DHHR Medicaid, Long Term Care Policy §514.8, states as follows:

> 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.

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 services 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 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.

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 Medicaid 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 required by 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 July 27, 2011 PAS reveals that the Claimant was demonstrating four (4) program qualifying deficits.

3) Evidence submitted at the hearing identifies one (1) additional program qualifying deficit in the area of vacating the building [in the event of an emergency].

4) Whereas the Claimant demonstrates five (5) qualifying deficits, medical eligibility for participation in the Medicaid Long-Term Care Program is established.

IX. DECISION:

It is the decision of the State Hearing Officer to **reverse** the Department's proposal to terminate the Claimant's application for Medicaid Long-Term Care (nursing facility) benefits based on the medical eligibility criteria.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this ___ Day of October, 2011.

_____

Thomas E. Arnett
State Hearing Officer