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 31, 2011

Attn: -----

RE: ----- Case No.: 11-BOR-1979

Dear -----:

Attached is a copy of the Findings of Fact and Conclusions of Law on the hearing held October 6, 2011 in the matter of -----. -----'s appeal was based on the Department of Health and Human Resources' proposal to terminate his 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 -----'s medical condition does not require a sufficient number of services and the degree of care necessary to qualify for Medicaid payment of nursing facility care.

It is the decision of the State Hearing Officer to **uphold** the Department's proposal to terminate -----'s 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

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

-----,

Claimant,

v. **Action Number: 11-BOR-1979**

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 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 6, 2011 on a timely appeal filed September 8, 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
-----, Ombudsman, Legal Aid of West Virginia (LAWV)
Kelley Johnson, Long-Term Care Program Manager, Bureau for Medical Services (BMS)
Stephanie Schiefer, 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.

IV. QUESTION TO BE DECIDED:

The question to be decided is whether the Claimant is medically eligible for the Medicaid Long-Term Care Program.

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 (pages 1-3)
D-2 Pre-Admission Screening (PAS) form - dated 8/9/11 (pages 4-9)
D-3 Notice of Denial Determination from WVMI - dated 8/11/11 (page 10)
D-4 Supporting Documentation (pages 11-200)

VII. FINDINGS OF FACT:

1) On August 9, 2011, a Pre-Admission Screening (PAS) form (Exhibit D-2) was completed on the Claimant and forwarded to West Virginia Medical Institute, hereinafter WVMI, by [redacted] Nursing and Rehabilitation Center. This form is used by the Department of Health and Human Resources, hereinafter Department, so that a determination of medical eligibility for continued participation in the Medicaid Long-Term Care (Nursing Facility) Program could be completed for the Claimant.

2) On or about August 11, 2011, the Claimant was notified that his 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 zero (0) areas identified below.**

3) The Department's Bureau for Medical Services (BMS), represented by Kelley Johnson, cited Medicaid regulations and called its witness (Stephanie Schiefer, RN) from WVMI to explain how Medicaid policy was applied to the medical findings documented on the Claimant's August 9, 2011 PAS (Exhibit D-2). According to the Department, the nursing facility completed the medical assessment and this documentation was relied upon by WVMI to identify qualifying deficits. Pursuant to the testimony provided by Stephanie Schiefer, RN, WVMI, Exhibit D-2 failed to identify any functional deficits. Subsequent to the Claimant's presentation contesting five (5) functional deficits, the Department stipulated that the Claimant was demonstrating two (2) functional deficits at the time of the assessment - bathing and grooming.

4) The Claimant, represented by Regional Ombudsman -----, contends that in addition to bathing and grooming, the Claimant is also demonstrating functional deficits in dressing, medication administration and vacating [in the event of an emergency]. These areas are addressed in Findings 5, 6 and 7.

5) The Claimant contends that he should have been awarded a deficit in dressing, as he requires hands-on physical assistance (Level 2 or higher). The Claimant testified that he is unable to put on his socks without assistance and that nursing facility staff must get his pants started to his knees before he can pull them up. The evidence indicates that the Claimant has difficulty maintaining balance in the standing position (D-4, page 77 CAA Worksheet/MDS) and that he must wear appropriate footwear due to his risk of falls (Exhibit D-4, page 137). Exhibit D-4, page 80 (CAA/MDS), indicates that the facility will continue with care planning for this resident with the goal toward minimizing risk factors for the prevention of falls. In addition, the July 27, 2011 MDS (D-4, page 25) indicates the Claimant required a 1-person assist with dressing.

   The Department cited information included in Exhibit D-4, page 98 (ADL Plan of Care September 2011), in its argument that the Claimant dresses independently. Because this document was generated subsequent to the medical assessment (September 2011), it is not relevant to the functional assessment (PAS) completed on August 9, 2011.

   Based on the evidence, the Claimant was demonstrating a functional deficit in dressing (Level 2, 1-person physical assistance) when the medical assessment was completed.

6) The Claimant testified that because he is unable to read and write, he is unable to administer his own medications. Exhibit D-4, Page 119, reveals that the Claimant is taking 13 different medications, all of which have specific dosage instructions. The Claimant further noted that he has cognitive loss/dementia as indicated in the MDS (D-4, page 44) and the CAA/MDS (D-4, page 58). The Claimant cited "Nurse's Notes" from July 30, 2011 (D-4, page 155), wherein it is recorded that the Claimant kicked the office door open and demanded pain medication that he was not allowed to have until 2 hours later. This, according to the Claimant, demonstrates that he is mentally unable to administer medications. The Department noted that the Claimant has mental capacity and makes his own decisions in the nursing facility. The Department cited Exhibit D-4, MDS Page 18, to show that the Claimant has no cognition impairment and no change in his baseline.

The Claimant cited information included in Exhibit D-4, page 98 (ADL Plan of Care for September 2011) to support his contention that he is unable to administer his own medications. However, because this document was generated subsequent to the August 9, 2011 PAS, it is not relevant for determining functional deficits at the time of the assessment.

Pursuant to testimony provided by RN Schiefer, and policy found in the Medicaid Provider Manual, Chapter 514, Attachment 1, an individual's ability to administer medication is assessed on the PAS as follows:

28.a. Yes
28.b. With Prompting and Supervision
28.c. No

A functional deficit is awarded only if the individual cannot administer medications (28.c). Because the Claimant needs to be reminded to take medications, and he requires supervision to ensure proper dosage, the Claimant can administer his medications with prompting and supervision. As a result, the Claimant was not demonstrating a deficit in medication administration at the time of the assessment.

7) The Claimant contends that he is unable to vacate [in the event of an emergency] because he is oxygen (O2) dependent (D-4, page 127 Progress Notes and D-4, page 146 Plan of Care). The Claimant purported that he is unable to put the oxygen tank on the back of his wheelchair and this would prohibit him from exiting in the event of an emergency.

The Department cited Nurse's Notes (Exhibit D-4, page 117, dated June 25, 2011) to show that the Claimant independently exited the facility in his wheelchair, got into his personal vehicle and left the facility. The Department contends that this is inconsistent with an individual who is unable to vacate. The Claimant initially testified that he has a friend who comes from Buckhannon to help him into his car, but later stated that he has only been in his vehicle one time since residing in the facility.

Evidence clearly demonstrates that the Claimant has difficulty ambulating and he is on continuous oxygen due to his respiratory illness. These conditions present an obvious barrier for vacating. Based on the evidence, the Claimant was demonstrating a functional deficit at the time of the medical assessment (PAS).

8) 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 August 9, 2011 PAS fails to indicate that the Claimant was demonstrating any program qualifying deficits, however, the Department stipulated during the hearing that the evidence demonstrates two (2) functional deficits – Bathing and Grooming.

3) Evidence submitted at the hearing identifies two (2) additional program qualifying deficits - Dressing and Vacating [in the event of an emergency].

4) Whereas the Claimant demonstrates only four (4) qualifying deficits, medical eligibility for participation in the Medicaid Long-Term Care Program cannot be established.

IX. DECISION:

It is the decision of the State Hearing Officer to **uphold** the Department's proposal to terminate the Claimant's 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