



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

Earl Ray Tomblin
Governor

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

April 7, 2011

Dear -----:

Attached is a copy of the findings of fact and conclusions of law on your hearing held on March 17, 2011. Your hearing request was based on the Department of Health and Human Resources' termination of Long Term Care Medicaid 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 two 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 proposed termination 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] Health Care, [REDACTED] WV

**WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW**

-----,
Claimant,

v.

Action Number: 11-BOR-417

**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 April 7, 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 March 17, 2011 on a timely appeal, filed January 11, 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
-----, Claimant's Daughter and Representative
-----, Claimant's Daughter and Witness
-----, Claimant's Brother and Witness
-----, Claimant's Sister-In-Law and Witness
-----, Director, ██████████ Healthcare Services of ██████████ Claimant's Witness
-----, RN Supervisor, ██████████ Healthcare Services of ██████████ Claimant's Witness

Kelley Johnson, WV Bureau of Medical Services, Department's Representative
Jens Wiik, 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 was whether the Department was correct in its determination that the Claimant was 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 December 15, 2010
- D-3 Notice of Denial Determination dated December 17, 2010

VII. FINDINGS OF FACT:

- 1) Claimant is a 49-year old female resident of ██████████ Healthcare Services of ██████████ a nursing and rehabilitation facility in ██████████ WV. Medical staff at ██████████ completed a Pre-Admission Screening (PAS) form on December 15, 2010 (Exhibit D-2) to assess the Claimant's medical eligibility for continuing nursing facility services.
- 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 two areas, *vacating a building in the event of an emergency* and *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 December 15, 2010, PAS (Exhibit D-2), her mother should have received deficits in a number of areas. These are as follows:

Eating – Claimant's representative testified that her mother could feed herself, but she was unable to cook, and was unable to determine for herself that it was time to prepare or eat a meal.

Bathing – Claimant's representative testified that her mother could get into and out of the bath or shower, but she did not know when she needed to take a bath.

Dressing – Claimant's representative testified that her mother could dress herself, but she often wore clothing that was inappropriate for the season, and at times walked out of her bedroom and out of her home without being completely dressed.

Grooming – Claimant's representative testified that her mother could brush her teeth and her hair, but she would not do so unless she was directed by someone else.

Continence – Claimant’s representative testified that her mother had to wear adult diapers. She stated her mother had incontinence accidents when she and her mother were together.

Orientation – Claimant’s representative testified that her mother gets very disoriented at times, and has short-term memory loss. She stated her mother can remember events from twenty years ago, but cannot recall something that was said or done five minutes in the past.

- 6) Claimant’s witness, the director of the nursing home at which Claimant resides, testified that Claimant’s condition has improved since she first arrived at the facility. He testified that he could not justify awarding another deficit on the PAS. He responded to the testimony of Claimant’s representative as follows:

Eating – Claimant’s witness testified that Claimant was physically able to feed herself, and that the inability to prepare food is not a basis on which to assess a deficit.

Bathing – Claimant’s witness testified that Claimant was physically able to take a bath or shower, with the supervision of nursing home staff.

Dressing – Claimant’s witness testified that Claimant could dress herself, with staff supervision to help her select season-appropriate clothing.

Grooming – Claimant’s witness testified that Claimant could brush her teeth and her hair with staff supervision.

Continence – Claimant’s witness testified that his staff did not record any continence accidents in her stay at his facility. He stated that as this hearing progressed, she excused herself twice to go to the bathroom.

Orientation – Claimant’s witness testified that Claimant does have moments of confusion, but that it was nowhere near the level of total disorientation required by policy.

VIII. CONCLUSION OF LAW:

Medical eligibility for Long Term Care Medicaid requires a minimum of five deficits in functional areas. The Department identified and awarded two deficits on the Claimant’s December 15, 2010, PAS. There was no testimony or evidence sufficient to substantiate findings of additional deficits for the Department. The Department was correct to terminate Long Term Care Medicaid based on the lack of medical eligibility for the program.

IX. DECISION:

It is the decision of the State Hearing Officer to **uphold** the Department’s proposed termination 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 7th Day of April, 2011.

**Stephen M. Baisden
State Hearing Officer**