State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
1027 N. Randolph Ave.
Elkins, WV 26241

Earl Ray Tomblin
Governor

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

February 24, 2012

----------for ----------

Dear ----------:

Attached is a copy of the Findings of Fact and Conclusions of Law on your father's hearing held February 22, 2012. Your hearing request was based on the Department of Health and Human Resources' denial of medical eligibility under the Medicaid Long-Term Care 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.

Medicaid Long-Term Care services are provided to eligible Medicaid individuals who reside in a nursing care or ICF/MR facility. Individuals eligible for coverage under this group must qualify medically. The medical evaluation assessment must establish the existence of a specified number and degree of functional care needs. (West Virginia Medicaid Manual Chapter 514, Section 514.8.2)

Information submitted at the hearing reveals that your father's condition as of his September 23, 2011 medical evaluation required a sufficient level of care (five functional deficits) to medically qualify for participation in the Medicaid Long-Term Care Program.

It is the decision of the State Hearing Officer to **reverse** the Department's determination that your father is medically ineligible for the Medicaid Long-Term Care Program.

Sincerely,

Pamela L. Hinzman
State Hearing Officer
Member, State Board of Review

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

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

IN RE: ----------,

Claimant,

vs. **ACTION NO.: 11- BOR- 2472**

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Respondent.

DECISION OF THE STATE HEARING OFFICER

I. INTRODUCTION:

This is a report of the State Hearing Officer resulting from a fair hearing 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 telephonically on February 22, 2012 on a timely appeal filed November 14, 2011 and received by the Hearing Officer on December 9, 2011. The hearing was originally scheduled for January 25, 2011, but was continued by the Hearing Officer.

II. PROGRAM PURPOSE:

Medicaid Long-Term Care 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 standards for the care provided to eligible recipients. In order to qualify for Nursing Home Care, an individual must meet both financial and medical eligibility criteria.

III. PARTICIPANTS:

----------, Claimant's Son and Attorney-In-Fact
----------, LPN, [redacted] Nursing and Rehabilitation Center
----------, Program Manager for Long-Term Care, Bureau for Medical Services
----------, RN, West Virginia Medical Institute

Presiding at the hearing was Pamela L. Hinzman, 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 514, Sections 514.8.1 and 514.8.2

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 West Virginia Medicaid Manual Chapter 514, Sections 514.8.1 and 514.8.2
D-2 Pre-Admission Screening form completed on September 23, 2011
D-3 Denial notice dated September 26, 2011
D-4 Minimum Data Set dated September 29, 2011

Claimant's Exhibits:

C-1 Sections 24-30 from Claimant's March 2011 PAS
C-2 Sections 22-42 from Claimant's September 23, 2011 PAS
C-3 Medicare claim information
C-4 Letter from [redacted] M.D.,(regarding date of service January 5, 2012)
C-5 Minimum Data Set dated June 30, 2011, nursing notes, Nursing Assistant Flow Sheet and POC Legend Report

VII. FINDINGS OF FACT:

1) A Pre-Admission Screening (PAS) medical evaluation (D-2) was completed for the Claimant on September 23, 2011 to determine medical eligibility for the Medicaid Long-Term Care Program. It was determined that the Claimant, who currently resides at [redacted] Nursing and Rehabilitation Center, is medically ineligible for the Medicaid Long-Term Care Program.

2) West Virginia Medical Institute (WVMI) Registered Nurse ---------- testified that two (2) qualifying functional deficits – physical assistance with bathing and inability to administer medication – were identified for the Claimant on the PAS assessment.

3) The Claimant was notified of the denial of Long-Term Care services in a letter dated September 26, 2011 (D-3).

4) The Claimant's witnesses contended that he should have received additional deficits in the

following areas:

Physical assistance with dressing- The Claimant's son, ----------, testified that the Claimant previously had chemotherapy treatment for cancer, which resulted in ongoing numbness in his fingers and toes. The Claimant's son contended that the Claimant is unable to feel buttons or tie his shoes. He stated that the Claimant wears mostly slip-on shoes and belts his pants instead of buttoning them.

The Claimant had been rated as being able to dress independently on the PAS completed in September 2011 by [redacted] M.D., therefore, no deficit had been awarded in this area of functionality. Minimum Data Set forms (D-4 and C-5) completed in June 2011and September 2011 indicate that the Claimant needed no physical assistance with dressing at that time.

Evidence fails to demonstrate that the Claimant required physical assistance with dressing at the time of the PAS.

Physical assistance with grooming- The Claimant's son testified that his father requires physical assistance with grooming as he is unable to trim his toenails. He provided Exhibit C-3, Medicare claim information, to verify that Medicare approved payments for nail debridement in June and August 2011.

The Claimant had been rated as being able to groom independently on the PAS, however, the Department did not dispute the Claimant's information concerning nail debridement.

Based on documentation provided during the hearing, one (1) additional deficit is awarded for physical assistance with grooming.

Inability to vacate the building in the event of an emergency- The Claimant's son provided a letter from [redacted] M.D., (C-4) to verify that the Claimant has macular degeneration and is legally blind. The Claimant's son testified that his father has been legally blind since 2007, cannot see the arrows on exit signs and is also hard of hearing. He believes the Claimant would have difficulty maneuvering in low light situations and may be unable to hear voice commands.

The Claimant had been rated as requiring supervision to vacate on the PAS, however, the Department did not dispute contentions that he would be unable to vacate without physical assistance.

Based on information provided during the hearing, it is reasonable to believe that the Claimant would require physical assistance with vacating in an emergency situation. Therefore, one (1) additional deficit is awarded for inability to vacate.

One-person physical assistance with walking- ----------, Licensed Practical Nurse at

[redacted] testified that the Claimant requires a walker, as well as one-person physical assistance with walking. Minimum Data Set information dated September 29, 2011 (D-4) – recorded in the ADL Support Provided section - indicates that the Claimant received one-person physical assistance with walking in his room and in the corridor.

The Claimant had been rated as requiring supervision and/or an assistive device for ambulation on the PAS, however, the Department did not contest testimony provided during the hearing.

Based on testimony and documentation, the Claimant is awarded one (1) additional deficit for one-person physical assistance with ambulation.

5) West Virginia Medicaid Manual Chapter, 514, Section 514.8.2 (D-1) states, in part:

> 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. These deficits may be any of the following:
>
> #24 Decubitis- 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 The individual has skilled nursing care needs in one or more of these areas: suctioning, tracheostomy, ventilator, parenteral fluids, sterile dressings or irrigations.

#28 Individual is not capable of administrating 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.

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 is utilized for physician certification of the medical needs of individuals applying for the Medicaid benefit. The PAS is completed and forwarded to the Bureau for Medical Services or its designee (West Virginia Medical Institute) for medical necessity review. Policy holds that to medically qualify for Medicaid Long-Term Care, an individual must have a minimum of five (5) qualifying deficits on the PAS. These deficits are derived from a combination of assessment elements on the medical evaluation.

2) Evidence reveals that a PAS was completed on September 23, 2011 and the Department determined that the Claimant is medically ineligible for Medicaid Long-Term Care Services. The Claimant's PAS revealed that he was awarded two (2) qualifying deficits in the areas of functional limitation.

   Based on information provided during the hearing, three (3) additional deficits are awarded to the Claimant.

3) The Claimant's total number of functional deficits has been elevated to five (5). Therefore, the required deficits have been established to meet medical eligibility requirements.

IX. DECISION:

It is the ruling of the State Hearing Officer to **reverse** the Department's decision to deny medical eligibility for the Medicaid Long-Term Care Program.

X. RIGHT OF APPEAL

See Attachment.

XI. ATTACHMENTS

The Claimant's Recourse to Hearing Decision.

Form IG-BR-29.

ENTERED this 24th day of February, 2011.

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Pamela L. Hinzman
State Hearing Officer

THE CLAIMANT'S RECOURSE TO HEARING DECISION

A. CIRCUIT COURT

An adverse decision of a State Hearing Officer is subject to judicial review through a Writ of Certiorari (West Virginia Code 53-3-1 et seq.) filed in the Circuit Court of Kanawha County within four (4) months from the date of the hearing decision.

The court may determine anew the decision or determination of the State Hearing Officer. In such appeals a certified copy of the hearing determination or decision is admissible or may constitute prima facie evidence of the hearing determination or decision. Furthermore, the decision may be appealed to the Supreme Court of Appeals of the State of West Virginia.

B. THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against because of race, color, national origin, age, sex or handicap, write immediately to the Secretary of the United States Department of Health and Human Services, Washington, D.C. 20201.

C. THE UNITED STATES DEPARTMENT OF AGRICULTURE

If the hearing decision involves food stamps and you believe you have been discriminated against because of race, color, national origin, age, sex or handicap, write immediately to the Secretary of the Department of Agriculture, Washington, D.C. 20250.