State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
4190 Washington Street, West
Charleston, WV 25313

Earl Ray Tomblin
Governor

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

February 10, 2012

----------for

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

Attached is a copy of the Findings of Fact and Conclusions of Law on your hearing held February 9, 2012. Your hearing request was based on the Department of Health and Human Resources' proposal to terminate ----------' medical eligibility for the Long Term Care Medicaid [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 the Long Term Care Medicaid program is based on current policy and regulations. These regulations provide that an individual must need direct nursing care twenty-four (24) hours a day, seven (7) days a week. The individual must have a minimum of five (5) deficits identified on the PAS [Pre-Admission Screening] to qualify for the Medicaid nursing facility benefit. (Nursing Facility Manual §514.8)

The information submitted at your hearing revealed that [redacted] meets the medical eligibility criteria for the Long Term Care Medicaid program.

It is the decision of the State Hearing Officer to **reverse** the proposal of the Department to deny [redacted] application for the Long Term Care Medicaid program.

Sincerely,

Cheryl Henson
State Hearing Officer
Member, State Board of Review

cc: Chairman, Board of Review / ---------- / Amy Workman, BMS / [redacted] Nursing Home Center

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

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

Claimant,

v. **ACTION NO.: 11-BOR-2540**

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 for ----------. This hearing was held in accordance with the provisions found in Chapter 700 of the West Virginia Department of Health and Human Resources' Common Chapters Manual. This hearing was convened on February 9, 2012.

It should be noted here that the Claimant's benefits under the Long Term Care program have continued pending a decision.

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. To qualify for Nursing Home Care, an individual must meet financial and medical eligibility criteria.

III. PARTICIPANTS:

----------, Claimant's representative

Kelley Johnson, Department representative
Traci Gillispie, Department witness

Presiding at the Hearing was Cheryl Henson, State Hearing Officer and a member of the Board of Review.

IV. QUESTION TO BE DECIDED:

The question to be decided is whether the Department's decision to deny the Claimant's Long Term Care Medicaid is correct.

V. APPLICABLE POLICY:

Nursing Facility Manual §514, 514.8.1, and 514.8.2

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 Nursing Facility Manual §514, 514.8.1, and 514.8.2
D-2 Pre-Admission Screening (PAS) dated November 17, 2011
D-3 Notice of Denial Determination dated November 18, 2011
D-4 Supporting Documentation

Claimant's Exhibits:

None

VII. FINDINGS OF FACT:

1) The Claimant was receiving services within [redacted] Center [redacted], a nursing facility, when on November 17, 2011, a Pre-Admission Screening (D-2), hereinafter PAS, was completed to determine her initial medical eligibility for Long Term Care [nursing facility], hereinafter LTC, Medicaid.

2) The Department subsequently determined, based on the November 17, 2011 PAS assessment findings, that the Claimant did not meet the medical eligibility requirements for the program. The Department sent the Claimant a notification letter (D-3) dated November 18, 2011, which included the following relevant information:

> YOUR REQUEST FOR LONG-TERM CARE (NURSING HOME) ADMISSIN HAS BEEN DENIED.
>
> REASON FOR DENIAL: Eligibility for long-term care placement being funded by the 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 five (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.

Vacate
Bathing
Dressing
Administering Medications

3) The Department's representative, Kelley Johnson, stipulated that the Claimant had met the criteria in those four areas. Ms. Johnson also stated that after reviewing the November 17, 2011 PAS (D-2) and comparing it with the supporting documentation (D-4), she was convinced that the Claimant also meets the criteria for receipt of a deficit in the area of transferring; however, she stopped short of reversing the Department's decision to deny the Claimant's medical eligibility for the program. She added that she had repeatedly tried to contact the nursing facility to discuss her findings prior to today's hearing, but was unable to speak with anyone. In order to receive a deficit in transferring, an individual must require at least one-person assistance to transfer. The supporting documentation (D-4) reveals that during November 2011 the Claimant was often receiving one-person assistance to transfer in the nursing facility.

4) Policy in the Nursing Facility Manual §514.8, 514.8.1, and 514.8.2 provides in pertinent part:

MEDICAID 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.

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 Decibitus – 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 0 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 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) Policy specifies that in order to be determined medically eligible for LTC [nursing facility] Medicaid, an individual must be found to require direct nursing care twenty-four (24) hours a day, seven (7) days per week. The individual must establish five (5) deficits during the PAS screening assessment.

2) The Claimant established four (4) deficits during her November 17, 2011 PAS assessment in the areas of vacating, bathing, dressing, and administering medications. She must receive at least one (1) additional deficit in order to qualify for the program.

3) During the hearing, the Department's representative conceded that the supporting documentation (D-4) provided from the nursing facility reveals that the Claimant was requiring one-person assistance for transferring during November 2011.

4) Policy specifies that to receive a deficit for transferring, an individual must require at least one-person physical assistance to transfer.

5) The totality of the evidence supports that the Claimant requires at least one-person assistance to transfer. The supporting documentation provided (D-4) shows that the Claimant required one-person physical assistance often during November 2011, the same month in which the PAS assessment occurred. The Department's representative did not dispute this finding. As a result, the Claimant is awarded one (1) additional deficit for transferring. When considered with her previously awarded four (4) deficits, her total awarded deficits now total five (5).

6) Based on the above findings, the Department was incorrect in its decision to deny the Claimant's application for LTC Medicaid.

IX. DECISION:

It is the decision of the State Hearing Officer to **reverse** the proposal of the Department to deny the Claimant's application for Long Term Care Medicaid.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 10th day of February, 2012.

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Cheryl Henson
State Hearing Officer