State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
203 East Third Avenue
Williamson, WV 25661

Earl Ray Tomblin
Governor

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

March 16, 201[redacted]

----------For: ----------

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

Attached is a copy of the Findings of Fact and Conclusions of Law on your client's hearing held on March 14, 2012. Her hearing request was based on the Department of Health and Human Resources' denial of Long Term Care Medicaid admission 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 determination of medical ineligibility for the program.

It is the decision of the State Hearing Officer to **uphold** the Department's denial 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
Kelley Johnson, WV Bureau for Medical Services
Amy Workman, Bureau of Medical Services

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

----------,

Claimant,

v. **ACTION NO.: 11-BOR-2599**

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 March 16, 2012 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 14, 2012 on a timely appeal, filed December 9, 2011. This hearing originally was scheduled for February 17, 2012, but was rescheduled at Claimant's request.

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:

----------, Long-term Care Ombudsman, Legal Aid of WV, Claimant's Representative
----------, Claimant
----------, Social Worker, [redacted] Nursing and Rehabilitation, Claimant's Witness

Kelley Johnson, WV Bureau of Medical Services, Department's Representative
Karen Keaton, 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 is whether the Department is correct in its determination that the Claimant is 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 October 21, 2011
D-3 Notice of Denial Determination dated October 27, 2011
D-4 Record Chart from [redacted] Nursing and Rehabilitation in [redacted], WV, for September 2011 and October 2011

Claimant's Exhibits:

C-1 Various records from [redacted] Nursing and Rehabilitation in [redacted], WV, from 2004 to 2011

VII. FINDINGS OF FACT:

1) Claimant is a 67-year-old female, who is currently residing in [redacted] Nursing and Rehabilitation (herein referred to as [redacted] Nursing) in [redacted], WV. Medical staff at [redacted] Nursing completed a Pre-Admission Screening (PAS) form on October 21, 2011 (Exhibit D-2) to assess the Claimant's medical eligibility for the WV Medicaid Long-Term Care program.

2) Department's representative submitted into evidence the Nursing Facility Services Provider Manual, Chapter 514, which 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 on the October 21, 2011 PAS (Exhibit D-2), the Claimant was assessed with no deficits.

4) The Department issued a Notice of Denial Determination (Exhibit D-3) to the Claimant on October 27, 2011. 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; thus your request for long-term care is being denied.

5) Claimant's representative asserted that on the October 21, 2011, PAS (Exhibit D-2), Claimant should have received deficits in a number of areas. These are as follows:

> ***Vacating a building during an emergency*** – The PAS indicated that Claimant could vacate a building during an emergency independently. Claimant's representative stated that Claimant is on continuous oxygen, she suffers from mental health issues that would cause her to have great

anxiety in the event of an emergency, and she takes several medications throughout the day, which have a depressive effect on her physical functioning. Claimant's representative argued that her breathing difficulties, her mental health issues, and her medications would prevent her from vacating the facility in the event of an emergency. Department's representative argued that records from [redacted] Nursing (Exhibit D-4) document in staff notes on several days Claimant walked out of the facility to smoke cigarettes in designated areas.

Bathing – The PAS indicated that [redacted] Nursing staff rated Claimant at Level 1 for this functional ability, meaning she was able to perform this activity of daily living independently. Claimant's Representative referred to Exhibit D-4, pages 13 through 17, wherein [redacted] Nursing staff chart the times a resident performs certain activities of daily living and if a staff member or members assisted in the activity in the month of September 2011. She submitted into evidence a similar collection of records for the month of October 2011. (Exhibit C-1.) She argued that these exhibits document at least fifteen occasions per month for September and October 2011 wherein [redacted] Nursing staff assisted Claimant in bathing.

Dressing – The PAS indicated that [redacted] Nursing staff rated Claimant at Level 1 for this functional ability, meaning she was able to perform this activity of daily living independently. Claimant's Representative referred to Exhibit D-4, pages 13 through 17, and Exhibit C-1. She argued that these exhibits document more than twenty occasions per month for September and October 2011 wherein [redacted] Nursing staff assisted Claimant with dressing.

Grooming – The PAS indicated that [redacted] Nursing staff rated Claimant at Level 1 for this functional ability, meaning she was able to perform this activity of daily living independently. Claimant's Representative referred to Exhibit D-4, pages 13 through 17, and Exhibit C-1, and argued that these exhibits document at least fifteen occasions per month in September and October 2011 wherein [redacted] Nursing staff assisted Claimant with her grooming needs.

Administering Medications – The PAS indicated that [redacted] Nursing staff determined Claimant was able to administer her medications, and assessed her with no deficit in this area. Claimant's Representative cited Exhibit D-4, page 43, Claimant's Minimum Data Set (MDS) from [redacted] Nursing, Section S, which states "Capable of self-administration of medications - No." Claimant's Representative argued that Claimant has an extensive list of medications that include pills and patches, and that her mental health issues and her poor reading skills make it difficult for her to take her medication properly. Department's Representative argued

that in order for Claimant to receive a deficit for administering medications, the documentation would have to indicate that Claimant could not physically pick up a pill and place it into her mouth; however, she agreed that in practicality, it would be difficult for someone with Claimant's mental status and limited literacy to manage her medications. Exhibit D-4 includes a [redacted] Nursing staff note from October 11, 2011 on page 19, which states, "Takes medications whole by mouth without difficulty."

6) Claimant's representative stated that in reviewing the PAS (Exhibit D-2) in comparison with the facility's records, she noted that the PAS appears to be inconsistent with the information located in these records.

VIII. CONCLUSION OF LAW:

1) Medical eligibility for Long Term Care Medicaid requires a minimum of five deficits from a set of functional life areas. The nursing home staff who conducted Claimant's October 21, 2011 PAS identified and assessed no deficits for the Claimant.

2) Claimant's representative argued that Claimant should have received deficits in the areas of *vacating a building during an emergency*, *bathing*, *dressing*, *grooming* and *administering medications.*

3) The submitted evidence indicates that Claimant should not have received a deficit for *vacating a building during an emergency*. There was ample documentation in Claimant's and Department's evidence that indicates Claimant regularly walks out of the facility to smoke cigarettes.

4) The submitted evidence indicates that Claimant should have received a deficit for *bathing*. There is ample documentation in Department's and Claimant's exhibits to indicate staff assisted with this functional ability.

5) The submitted evidence indicates that Claimant should have received a deficit for *dressing*. There is ample documentation in Department's and Claimant's exhibits to indicate staff assisted with this functional ability.

6) The submitted evidence indicates that Claimant should have received a deficit for *grooming*. There is ample documentation in Department's and Claimant's exhibits to indicate staff assisted with this functional ability.

7) The submitted evidence indicates that Claimant should have received a deficit for *administering medications*. The documentation indicates Claimant is prescribed many medications, and it is not reasonable to expect someone with Claimant's limited literacy and mental health issues to keep these medications organized, or to take them as per instructions.

8) Claimant should have received deficits for *bathing*, *dressing*, *grooming* and *administering medications*. However, based on her October 21, 2011 PAS and documentation from her nursing facility, she does not have enough deficits to meet the medical criteria for the Medicaid Long-Term Care program.

IX. DECISION:

It is the decision of the State Hearing Officer to **uphold** the Department's proposed denial 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 16th Day of March, 2012.

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Stephen M. Baisden
State Hearing Officer