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

June 21, 2012

Dear ------:

Attached is a copy of the Findings of Fact and Conclusions of Law for your hearing held on June 19, 2012. Your appeal was based on the Department of Health and Human Resources' action to deny your application for 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 the Medicaid Long Term Care (Nursing Facility) Program 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 your hearing fails to demonstrate that your medical condition requires 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 action to deny your application for Medicaid Long-Term Care Program benefits.

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 AND HUMAN RESOURCES
BOARD OF REVIEW

------,

Claimant,

v. **Action Number: 12-BOR-1188**

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 the Common Chapters Manual, Chapter 700 of the West Virginia Department of Health and Human Resources. This fair hearing was convened telephonically on June 19, 2012, on a timely appeal filed April 30, 2012.

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
------, Claimant's mother/representative
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 or not the Department is correct in its action to deny the Claimant's application for Medicaid Long-Term Care Program benefits.

V. APPLICABLE POLICY:

West Virginia Medicaid Manual, Chapter 500, Section 514

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 Pre-Admission Screening (PAS) form - dated 4/23/12 (pages 1-11)
D-2 Notice of Denial For Long-Term Care (Nursing Home) - dated 4/23/12 (pages 12 & 13)
D-3 WV Medicaid Manual, Chapter 500, Section 514 (pages 14-17)

VII. FINDINGS OF FACT:

1) On April 23, 2012, a Pre-Admission Screening (PAS) form (Exhibit D-1) was completed by ----------Center, signed by the Claimant's physician, and forwarded to West Virginia Medical Institute (WVMI) to evaluate the Claimant's medical eligibility for participation in the Medicaid Long-Term Care (Nursing Facility) Program.

2) On or about April 23, 2012, the Claimant was notified that her request for Medicaid Long-Term Care benefits was denied (D-2). 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 three (3) areas identified below** – Bathing, Grooming and Dressing.

3) The Respondent'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 April 23, 2012, PAS (Exhibit D-1). As a matter of record, the Department stipulated that the PAS submitted for review confirms the Claimant is demonstrating three (3) functional deficits (Bathing, Grooming and Dressing), however, five (5) functional deficits must be identified in order to establish medical eligibility.

4) The Claimant and her representative contended that she should have been found medically eligible to participate in the Medicaid Long-Term Care Program as she is also demonstrating functional deficits in eating, walking and medication administration. The following will address the contested areas:

Eating – The Claimant was assessed at a Level 1 (independent) in Exhibit D-1, but the Claimant's representative indicated the Claimant should qualify for a deficit in eating because she is unable to prepare meals for herself. Pursuant to Medicaid policy §514.8.2 – the individual must require physical assistance to get nourishment in order to qualify for a deficit in eating - meal preparation is not considered when evaluating a deficit. As a result, the Claimant does not qualify for a functional deficit in eating based on her inability to prepare food.

Walking – According to policy, an individual must require hands-on (one person) physical assistance in order to qualify for a functional deficit in walking. The Claimant's representative purported that the Claimant is unable to walk from her chair to the bathroom without getting short of breath; however, this fails to qualify for a functional deficit in walking, as the Claimant is able to ambulate without physical assistance.

Medication Administration – A functional deficit is identified in this area only if the individual is incapable of administering his/her own medications. This could include the placement of a pill in their mouth, inability to apply pain patches, eye drops, injections, etc… Testimony presented at the hearing reveals that the Claimant must sometimes be reminded to take her medications. This information is consistent with the Claimant's assessed functional ability – she requires prompting and supervision – and this level of assistance does not qualify for a functional deficit in the area of medication administration.

5) 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 April 23, 2012, PAS indicates that the Claimant was demonstrating three (3) program qualifying functional deficits – Bathing, Dressing and Grooming.

3) Evidence submitted at the hearing fails to identify any additional program qualifying functional deficits.

4) Whereas the Claimant was demonstrating only three (3) functional deficits at the time of the April 2012 medical assessment, the Respondent was correct in it decision to deny medical eligibility for participation in the Medicaid Long-Term Care Program.

IX. DECISION:

It is the decision of the State Hearing Officer to **uphold** the Department's decision to deny 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 June, 2012.

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Thomas E. Arnett
State Hearing Officer