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

Rocco S. Fucillo
Cabinet Secretary

July 9, 2012

Dear ------:

Attached is a copy of the Findings of Fact and Conclusions of Law for your hearing held on June 29, 2012. Your appeal was based on the Department of Health and Human Resources' proposal to terminate your 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 continues to require 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 proposal to terminate your 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-1301**

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 29, 2012, on a timely appeal filed April 20, 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 sister/witness
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 was correct in its proposal to terminate the Claimant's 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 Scheduling Order (pages 1-4)
D-2 WV Medicaid Manual, Chapter 500, Section 514 (pages 5-7)
D-3 Pre-Admission Screening (PAS) form - dated 4/9/12 (pages 8-13)
D-4 Notice of Denial for Long-Term Care (Nursing Home) - dated 4/10/12 (page 14)
D-5 Physician Capacity Statement, Claimant's signed Hearing Request and Release of Medical Records (pages 15-19)
D-6 Supporting clinical documentation (pages 20-88)

VII. FINDINGS OF FACT:

1) On April 9, 2012, a Pre-Admission Screening (PAS) form (Exhibit D-3) was completed by -----, signed by the Claimant's physician, and forwarded to West Virginia Medical Institute (WVMI) to evaluate the Claimant's medical eligibility for continued participation in the Medicaid Long-Term Care (Nursing Facility) Program.

2) On or about April 10, 2012, the Claimant was notified that his request for Medicaid Long-Term Care benefits was denied (Exhibit D-4). 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.**
>
> **REASON FOR DECISION: 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 one (1) area identified below** – Administering Medications.

3) The Respondent's Bureau for Medical Services (BMS), represented by Kelley Johnson, cited Medicaid regulations and called its witness (Karen Casey, RN) from WVMI to explain how Medicaid policy was applied to the medical findings documented on the Claimant's April 9, 2012, PAS (Exhibit D-3). As a matter of record, the Department stipulated that the PAS submitted for review confirms the Claimant is demonstrating one (1) functional deficit (Administering Medications), however, five (5) functional deficits must be identified in order to establish medical eligibility.

4) The Claimant and his witness contended that he should have been found medically eligible to participate in the Medicaid Long-Term Care Program as he is also demonstrating functional deficits in bathing, dressing, walking, transferring and vacating [in the event of an emergency]. The following will address the contested areas:

Bathing – The Claimant was assessed at a Level 1 (self/prompting) in the functional area of bathing on the PAS (Exhibit D-3), but he contends that he cannot stand up to bathe while holding onto something, so he must use a shower chair. The Claimant further stated that he currently gets physical assistance from nursing facility staff when bathing. The Department cited the MDS (Minimum Data Set) dated March 29, 2012, Exhibit D-6, page 30, and noted that this information is documented by nursing facility staff to bill Medicaid for services provided. This document indicates that the Claimant bathes independently. In addition, the Nursing Assistant Data Sheet (Exhibit D-6, page 59) indicates that when the Claimant did not refuse to bathe, he was able to complete the task independently. The clinical evidence confirms that the Claimant does not require hands-on physical assistance with bathing. As a result, the Claimant is not demonstrating a functional deficit in bathing.

Dressing – The Claimant purported that he is unable to dress in the seated or standing position. The Claimant's sister purported that it is difficult for the Claimant to do two things at one time, and that standing while dressing is difficult. Documentation found in the MDS (Exhibit D-6, page 29), reveals that nursing facility staff members have documented that the Claimant is independent (no staff or oversight at any time), and that he does not require setup or physical help from staff. Based on the clinical documentation, the Claimant was correctly assessed as a Level-1 (self/prompting) in dressing. Because the Claimant does not require hands-on physical assistance, a deficit cannot be established in dressing.

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 initially reported that he cannot walk at all, but later indicated that he can ambulate some with a walker, although someone needs to hold onto his pants due to poor balance. It was further reported that the Claimant's primary method of ambulation, however, is in a wheelchair. Information found in the MDS (Exhibit D-6, page 29) reveals that the Claimant requires limited, one-person assistance (staff provides guided maneuvering of limbs or other non-weight bearing assistance), with walking. While it is unclear if the Claimant always requires assistance with walking, the evidence demonstrates that the Claimant requires, at a minimum, situational hands-on physical assistance. A deficit in walking (Level-2) is supported by the evidence.

Transferring – The Claimant reported that he has to use his foot to pry himself out of bed and then uses his foot to assist with getting into his wheelchair. No other areas of transferring were reported to be problematic by the Claimant. Documentation found in the MDS (Exhibit D-6, page 29) reveals that nursing facility staff has documented the Claimant is independent and requires no setup or physical help from staff to transfer. A review of Nursing Progress Notes (Exhibit D-6, pages 56-58) documented in March and April 2012 indicates the Claimant transferred independently on each occasion, and the Nursing Assistant Data Sheet (Exhibit D-6, page 59) further confirms that the Claimant was able to transfer independently. Based on the evidence, the Claimant was correctly assessed as a Level-1 (independent), and does not qualify for a functional deficit in transferring.

Vacating – The PAS indicates the Claimant was assessed as requiring supervision while vacating in the event of an emergency, however, ------, Claimant's sister, purported that the Claimant would not be able to vacate the facility quickly due to difficulty with transferring and slow ambulation. While the Claimant is able to transfer independently (with effort), his ability to ambulate (walking or wheeling) swiftly during an emergency is suspect. Upon consideration of the testimony and documentation, the Claimant is demonstrating a deficit in vacating and would require physical assistance to vacate.

5) WVDHHR 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:
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> - 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.
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> **514.8.1 APPLICATION PROCEDURE**
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> 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 individual's evaluating physician.

2) The April 10, 2012, PAS indicates that the Claimant was demonstrating one (1) program qualifying functional deficit – administering medications.

3) Evidence submitted at the hearing identified two (2) additional program qualifying functional deficits – walking and vacating.

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 July, 2012.

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Thomas E. Arnett
State Hearing Officer