State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
P.O. Box 1736
Romney, WV 26757

Earl Ray Tomblin
Governor

Rocco S. Fucillo
Cabinet Secretary

October 16, 2012

Dear ------:

Attached is a copy of the Findings of Fact and Conclusions of Law on your hearing held October 4, 2012. Your hearing request was based on the Department of Health and Human Resources' decision to deny your medical eligibility for Long-Term Care Medicaid.

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 direct nursing care twenty-four hours a day, seven 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 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).

Clinical information submitted at your hearing revealed that you no longer meet the eligibility requirements for Long-Term Care Medicaid.

It is the decision of the State Hearing Officer to uphold the proposal of the Department to terminate your eligibility for Long-Term Care Medicaid.

Sincerely,

Eric L. Phillips
State Hearing Officer
Member, State Board of Review

cc: Erika Young-Chairman, Board of Review
Stacy Broce-Bureau for Medical Services

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

IN RE: ------,

Claimant,

v. **ACTION NO.: 12-BOR-1561**

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 fair hearing was convened on October 4, 2012, on a timely appeal, filed June 18, 2012.

It should be noted here that the Claimant's benefits under the Long-Term Care Medicaid program continue at the previous level of determination pending a decision from the State Hearing Officer.

This hearing was originally scheduled to convene on August 7, 2012. It was rescheduled to August 15, 2012, based on requested continuance from the Department. The Claimant failed to appear at the August 15, 2012, hearing; however, he present good cause for his failure to appear on said date and the hearing was rescheduled to September 19, 2012. The Claimant requested a continuance prior to the scheduled hearing due to his own hospitalization. The hearing was rescheduled to October 4, 2012, the date in which it was completed.

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 witness
Kelly Johnston, Department representative

Presiding at the hearing was Eric L. Phillips, State Hearing Officer and a member of the 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 medical eligibility for Long-Term Medicaid assistance.

V. APPLICABLE POLICY:

Bureau for Medical Services Provider Manual Chapter 514

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 Bureau for Medical Services Provider Manual Chapter 514
D-2 Pre-Admission Screening dated June 6, 2012
D-3 Notice of Decision dated June 7, 2012
D-4 ------ Physician Determination of Capacity dated May 18, 2012

VII. FINDINGS OF FACT:

1) On June 6, 2012, a Pre-Admission Screening (PAS) (Exhibit D-2) was forwarded to West Virginia Medical Institute (WVMI) by ------ (Facility), in order to determine the Claimant's continued medical eligibility for Long-Term Care Medicaid assistance.

2) Kelly Johnston, Bureau for Medical Services Program Manager for Long-Term Care Facilities, testified that an individual must demonstrate five substantial deficits on the PAS in order to qualify medically for Long-Term Care Medicaid assistance (Exhibit D-1). Ms. Johnston testified that the Claimant met the severity criteria in the areas of dressing and walking.

3) On June 7, 2012, the Department issued the Claimant a Notice of Denial (Exhibit D-3) informing him of the termination of his medical eligibility for Long-Term Care Medicaid. This notice documents in pertinent part:

> 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 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 Denial: 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 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 two areas-dressing and walking.

4) The Claimant contended that he met the severity criteria on the PAS assessment in the areas of decubitus, wheeling, transferring, bathing, grooming and orientation.

5) The Claimant testified that during a June 2012, hospitalization, he was being treated for a decubitus ulcer on his back. Ms. Johnston testified that at the time of PAS assessment, the completing physician did not indicate that the Claimant suffered from any decubitus ulcers. Ms. Johnston noted that clinical evidence submitted with the PAS assessment (Exhibit D-4) documented that the Claimant was a risk for developing pressure ulcers; however, he was not exhibiting any pressure ulcers at the time of the assessment.

6) The Claimant testified that he has "no power in his arms and legs" and is unable to wheel himself. The Claimant added that his wheeling ability is affected by his knees, which are permanently bent due to his physical condition. During the PAS assessment, the Claimant's wheeling ability was assessed at Level 2. The clinical evidence submitted with PAS (Exhibit D-4) documents that the Claimant required no assistance with wheeling.

7) The Claimant testified that due to problems with his back, he is unable to transfer and the facility must utilize a "Hoyer Lift" for assistance with his transfer in and out of bed. The PAS assessment documents the Claimant's transferring ability at Level 1, requiring no assistance. The clinical evidence submitted with the PAS assessment (Exhibit D-4) documents that Claimant did not require assistance with bed mobility.

8) The Claimant indicated that due to his neuropathy, the facility administers his showers because he lacks the sensation to determine cold and hot. The PAS assessment documented the Claimant's bathing ability at Level 1, requiring no assistance.

9) The Claimant indicated that he cannot participate with grooming due to poor grip in his hands and fingers. The Claimant purported that he is unable to use fingernail clippers or push a comb through his hair. The PAS assessment documented the Claimant's grooming ability at Level 1,

10) The Claimant testified that his prescribed medications cause him severe depression, disorientation and loss of memory. The clinical evidence submitted with the PAS assessment (Exhibit D-4) documented that the Claimant was of sufficient mental capacity and was oriented to the year, month, and day.

11) Bureau for Medical Services Provider Manual Chapter 514.8.2 documents:

> 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: 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 person 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 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.

VIII. CONCLUSIONS OF LAW:

1) Policy reveals that to qualify medically for nursing facility benefits, an individual must need direct nursing care twenty-four hours a day, seven 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.

2) Policy reveals that an individual must have a minimum of five (5) deficits identified on the PAS, to qualify medically for the Medicaid nursing facility benefit.

3) The Claimant's June 2012 PAS assessment revealed two qualifying deficits in the areas of dressing and walking.

4) The Claimant's contention that he should be awarded a deficit for a decubitus ulcer is not supported by evidence. Policy requires that a deficit is awarded for a decubitus ulcer when the ulcer has progressed to stage 3 or 4. There was no indication in the PAS assessment that the Claimant suffered from any decubitus ulcer. While clinical evidence revealed the Claimant was at risk for a decubitus ulcer, there was no evidence presented to document that the Claimant suffered from a decubitus ulcer at the time of the assessment. Therefore, an additional deficit in the contested area cannot be awarded.

5) The Claimant's contention that he should be awarded a deficit in the area of wheeling is not supported by evidence. Policy requires that a deficit is awarded for wheeling when the individual is assessed at Level 3 or higher. The clinical evidence submitted revealed that the Claimant required no assistance with his ability to wheel himself and completing physician assessed the Claimant as a Level 2 on the PAS. Therefore, an additional deficit in the contested area cannot be awarded.

6) The Claimant's contention that a deficit should be awarded in the area of transferring is not supported by evidence. Policy requires that a deficit is awarded in the area of transferring when the individual is assessed at Level 3 or higher, meaning that one or two person assistance is required to aid in the individual's ability to transfer. The Claimant was assessed at Level 1, requiring no assistance, on the PAS assessment and clinical evidence revealed that the Claimant did not require assistance with bed mobility. Therefore, an additional deficit in the contested area cannot be awarded.

7) The Claimant's contention that a deficit should be awarded in the area of bathing is not supported by evidence. Policy requires that a deficit is awarded in the area of bathing when the individual is assessed at Level 2 or higher, meaning that physical assistance is required to aid in the individual's ability to bathe him or herself. The Claimant was assessed at Level 1, requiring no assistance, on the PAS assessment; therefore, an additional deficit in the contested area cannot be awarded.

8) The Claimant's contention that a deficit should be awarded in the area of grooming is not supported by evidence. Policy requires that a deficit is awarded for grooming when the individual is assessed at Level 2 or higher, meaning that physical assistance is required to aid in

the individual's grooming abilities. The Claimant was assessed at Level 1, requiring no assistance, on the PAS assessment and clinical evidence revealed that the Claimant did not require assistance with his personal hygiene. Therefore, an additional deficit in the contested area cannot be awarded.

9) The Claimant's contention that a deficit should be awarded in the area of orientation is not supported by evidence. Policy requires that a deficit for orientation is awarded when the individual is assessed at Level 3 or higher, meaning they are considered totally disoriented or comatose. During the assessment, the Claimant exhibited sufficient mental capacity and was oriented to person, place and time; therefore, an additional deficit in the contested area cannot be awarded.

10) Evidence and testimony submitted during the hearing process failed to establish additional qualifying deficits; therefore, the Department was correct in its decision to deny the Claimant's medical eligibility for Long-Term Care Medicaid.

IX. DECISION:

It is the decision of the State Hearing Officer to uphold the proposal of the Department to terminate the Claimant's medical eligibility for the Long-Term Care Medicaid program.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this _____ day of October 2012.

_____

Eric L. Phillips
State Hearing Officer