STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL

Earl Ray Tomblin
Governor

BOARD OF REVIEW
4190 Washington Street, West
Charleston, West Virginia 25313

Karen L. Bowling
Cabinet Secretary

March 25, 2015

[redacted]

RE: [redacted] v. WV DHHR
ACTION NO.: 15-BOR-1377

Dear Mr. [redacted]

Enclosed is a copy of the decision resulting from the hearing held in the above-referenced matter.

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.

You will find attached an explanation of possible actions you may take if you disagree with the decision reached in this matter.

Sincerely,

Donna L. Toler
State Hearing Officer
Member, State Board of Review

Encl: Claimant's Recourse to Hearing Decision
Form IG-BR-29

cc: Stacy Broce, BMS

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Claimant,

v. **Action Number: 15-BOR-1377**

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES,

Respondent.

DECISION OF STATE HEARING OFFICER

INTRODUCTION

This is the decision of the State Hearing Officer resulting from a fair hearing for [redacted]. 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 March 17, 2015, on an appeal filed February 23, 2015.

The matter before the Hearing Officer arises from the January 27, 2015 decision by the Respondent to deny the Claimant's application for Medicaid Long-Term Care benefits.

At the hearing, the Respondent appeared by Kelley Johnson, Program Manager, Bureau for Medical Services. The Claimant appeared *pro se*. Appearing as a witness for the Claimant was [redacted], the Claimant's son and Power of Attorney. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

- D-1 Bureau for Medical Services Policy Manual, Chapter 514 - Covered Services, Limitations and Exclusions for Nursing Facility Services
- D-2 Pre-Admission Screening (PAS) form dated January 23, 2015
- D-3 Physician Determination of Capacity
- D-4 Documentation submitted from facility/physician
- D-5 Notice of Denial for Long-Term Care (Nursing Home) dated January 27, 2015

After a review of the record, including testimony, exhibits, and stipulations admitted into evidence at the hearing, and after assessing the credibility of all witnesses and weighing the evidence in consideration of the same, the Hearing Officer sets forth the following Findings of Fact.

FINDINGS OF FACT

1) On January 23, 2015, the Claimant was evaluated to determine medical eligibility for participation in the Medicaid Long-Term Care Program. The Pre-Admission Screening (PAS) form was signed by [redacted], Psychologist, and identified two (2) functional deficits – Medication Administration and Grooming. (Exhibits D-2 and D-5)

2) On or about January 27, 2015, Respondent issued notice to the Claimant of its decision to terminate Medicaid Long-Term Care Program benefits as a result of the determination that he did not meet medical criteria for the program. As a matter of record, the Respondent stipulated that the Claimant demonstrated two (2) functional deficits (Medication Administration and Grooming) at the time of the assessment, but because a minimum of five (5) deficits must be identified, continued medical eligibility could not be established. (Exhibit D-5)

3) The Claimant's witness contended that since the time of the PAS the Claimant has experienced deterioration in his condition due to several health issues including diabetes and hip replacement issues preventing him from making progress with his physical therapy. The Claimant's witness contended the Claimant should be determined eligible for Medicaid payment of nursing facility care because he is demonstrating functional deficits in the areas of bathing, transferring, walking, and incontinence of the bladder and bowels.

4) The following will address the findings specific to each of the contested functional areas:

   Bathing – In order to qualify for a functional deficit in bathing, the individual must require, at a minimum, one (1)-person physical assistance. The Claimant was identified on the PAS as a level 1(self/prompting) by his treating physician. The Claimant's witness argued that the Claimant needs assistance with bathing, but did not elaborate. A review of the documentation kept by facility staff, which includes the Minimum Data Set (MDS), and the Assisted Daily Living (ADL) Flow Sheet Log, reveals the Claimant was independent in the functional area of bathing when the PAS assessment was completed. The evidence does not identify a functional deficit in the area of bathing. (Exhibit D-2 and D-4)

   Walking and Transferring – Policy stipulates that an individual must require physical assistance from at least one (1) person to qualify for a functional deficit in the areas of transferring and walking. The Claimant's witness contended that due to a worsening in his condition he requires constant supervision when walking and transferring (such as getting in and out of a car). The Claimant reported that the nurse watches him when he gets in and out of his wheelchair. He added that he can walk about 200 feet with his walker if he takes rest periods and is supervised by his nurse. A review of the MDS and ADL Flow reveals that the only level of assistance provided by facility staff has been

supervision. This information, considered in conjunction with the Claimant's testimony indicating he can walk and transfer with supervision, confirms the Claimant is not demonstrating functional deficits in walking and transferring. (Exhibits D-2 and D-4)

Incontinence (Bladder and Bowels) – The Claimant testified that he experiences incontinence of the bladder one to two times per day and incontinence of the bowels every other night. The Claimant stated he has never been continent of the bladder, that he believed he had a catheter placed at the time of the PAS and has worn adult protective undergarments since the catheter was removed. However, the Claimant could not remember the exact dates he had a catheter placed nor when it was removed. A review of the MDS reveals that the Claimant had no catheter at the time of the PAS and was continent of the bladder and bowels at the time of the assessment. As a result, the Claimant is not demonstrating a functional deficit in the area of incontinence.

APPLICABLE POLICY

According to the West Virginia Bureau for Medical Services Medicaid Provider Manual §514.6.3, to qualify medically for the nursing facility Medicaid benefit, an individual must need direct nursing care 24 hours a day, 7 days a week. BMS has designated a tool known as the Pre-Admission Screening form (PAS) (see appendix II) 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 deficits identified on the PAS. These deficits will be determined based on the review by BMS/designee 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 the 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. Department of Health and Human Resources Chapter 514: Nursing Facility Services Page 30 January 1, 2013 DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

- #27: Individual has skilled needs in one 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.

  This assessment tool must be completed, signed and dated by a physician. The physician's signature indicates "to the best of my knowledge, the patient's medical and related needs are essentially as indicated". It is then forwarded to the Bureau or their designee for medical necessity review. The assessment tool must be completed and reviewed for every individual residing in a nursing facility, regardless of the payment source for services.

DISCUSSION

Regulations that govern the Medicaid Long-Term Care (Nursing Facility) Program stipulate that an individual must require hands-on physical assistance in the functional areas of bathing, walking and transferring to qualify for a functional deficit. While the evidence submitted at the hearing reveals the Claimant may have experienced deterioration in his condition since the time of the PAS, there was no evidence to indicate he required hands-on physical assistance with any of the contested activities of daily living at the time the PAS was conducted. The Claimant was unable to recall the exact dates his catheter was placed and removed, and evidence presented by the Department established that the Claimant was continent of the bladder and bowels at the time the PAS was completed.

CONCLUSIONS OF LAW

The Claimant demonstrated two (2) functional deficits (Grooming and Medication Administration) on the date of the assessment and – as a result of information provided during the hearing – no additional deficits were identified. Because five (5) deficits have not been identified, medical eligibility for the Medicaid Long-Term Care Program cannot be established.

DECISION

It is the decision of the State Hearing Officer to **uphold** the Department's decision to deny the Claimant's application for benefits and services provided through the Medicaid Long-Term Care Program.

ENTERED this ____Day of March 2015.

_____

Donna L. Toler
State Hearing Officer