State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
P. O. Box 2590
Fairmont, WV 26555-2590

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

June 29, 2006

____ for
____
____
____

Dear Mr. ____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held May 18, 2006. Your hearing request was based on the Department of Health and Human Resources' decision to find you medically ineligible for the Medicaid Long-Term Care 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.

Medicaid Long-Term Care Services are provided to eligible Medicaid individuals who reside in a nursing care or ICF/MR facility. Individuals eligible for coverage under this group must qualify medically. The medical evaluation assessment must establish the existence of a specified number and degree of functional care needs. (West Virginia Income Maintenance Manual Sections 17.1, 17.11 and West Virginia Medicaid Manual, Section 508.2)

Information submitted at the hearing reveals that your medical condition, at the time of the December 28, 2005 evaluation, required a sufficient level of care (five functional deficits) to medically qualify you for participation in the Medicaid Long-Term Care Program.

It is the decision of the State Hearing Officer to **reverse** the Agency=s determination that you are medically ineligible for participation in the Medicaid Long-Term Care Program. Medical eligibility is therefore established effective December 28, 2005.

Sincerely,

Thomas E. Arnett
State Hearing Examiner
Member, State Board of Review

cc: Chairman, Board of Review
Emily Keefer, Bureau for Medical Services, DHHR

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES

____,

Claimant,

vs. **Action Number 05-BOR-6548**

West Virginia Department of Health & Human Resources,

Respondent.

SUMMARY AND DECISION OF THE STATE HEARING OFFICER

I. INTRODUCTION:

This is a report of the State Hearing Officer resulting from a fair hearing concluded on June 29, 2006 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 originally convened on May 18, 2006 on a timely appeal filed February 15, 2006.

II. PROGRAM PURPOSE:

The Program entitled **Medicaid Long-Term Care** (nursing facility services) is set up cooperatively between the Federal and State governments and administered by the West Virginia Department of Health & Human Resources.

Nursing Home Care 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 standards for the care provided to eligible recipients. In order to qualify for Nursing Home Care, an individual must meet both financial and medical eligibility criteria.

III. PARTICIPANTS:

____, Claimant's Sister/Representative
____, Claimant's Nephew/Representative
Kortni Steart, ESW, DHHR (observing)
Emily Keefer, RN, Program Manager, Long-Term Care Program, BMS, DHHR (participating telephonically)
Oretta Keeney, RN, West Virginia Medical Institute (participating telephonically)

Presiding at the hearing was Thomas E. Arnett, State Hearing Examiner and a member of the State Board of Review.

IV. QUESTION TO BE DECIDED:

The question to be decided is whether the Claimant is medically eligible for the Medicaid Long-Term Care Program.

V. APPLICABLE POLICY:

West Virginia Income Maintenance Manual Sections 17.1 and 17.11.
West Virginia Medicaid Manual Section 508.2

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits
D-1 West Virginia Medicaid Manual Section 508.2
D-2 PAS-2005 form completed on 12/28/05
D-3 Denial Notice dated 1/18/06

Claimant's Exhibits
C-1 Letter from [redacted] N.H.A., Assistant Administrator, [redacted] Center, dated 3/9/06
C-2 Notification from WV DHHR – Information needed to establish eligibility, dated 3/6/06.

VII. FINDINGS OF FACT:

1) On December 28, 2005, a Pre-Admission Screening, hereinafter PAS, was completed by [redacted] Center to determine if the Claimant was medically eligible to participate in the Medicaid, Long-Term Care (Nursing Home) Program (Exhibit D-2).

2) The PAS was forwarded to West Virginia Medical Institute (WVMI) where the determination was made that the Claimant did not meet the medical eligibility criteria.

3) On or about January 18, 2006, the Department, through WVMI, notified the Claimant that his request for Long-Term Care (Nursing Home) admission was denied. This notice states in pertinent part:

> 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. Your request for long-term care is being denied. The PAS (Pre-Admission Screening Form), reflected deficiencies that meet the severity criteria in 4 areas - Bathing, Grooming, Dressing and Administering Medications.

4) The Claimant was admitted to the [redacted] facility on or about August 15, 2005. He was cut from Medicare status on September 19, 2005 and placed in private pay status without notification from Pine View. This issue has reportedly been brought to the attention of the appropriate licensing officials and is currently being reviewed. A PAS should have been competed immediately, however, there is evidence to confirm that a PAS was requested in October 4, 2005 (see Exhibit C-2), but it was not completed by the nursing facility until almost 3 months later.

5) The Claimant's representatives are asking that the Claimant be approved for Medicaid coverage from December 1, 2005 (the date an application was made at the local DHHR) through January 12, 2006 (the date the Claimant was removed from [redacted] However, policy found in the West Virginia Medicaid Manual Section 508 states that eligibility 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 physician signature on the medical assessment tool; or The date of admission to the nursing facility.

In this case, eligibility could not have been established until the physician signed the PAS as it occurred last – December 28, 2005.

6) Representatives appearing on behalf of the Claimant testified that while the PAS was signed by a physician on December 28, 2005, the PAS was completed by someone else and remained on the physician's desk from at least the beginning of December 2005. Additionally, the Claimant's representatives testified that because [redacted]s physician did not complete the PAS, the information contained in the PAS is inaccurate. The Claimant's representatives also contend that the findings on the PAS were self-serving to the facility because it was beneficial to them to make the Claimant private pay.

7) Exhibit C-1 is a letter from [redacted] Center Assistant Administrator, [redacted] N.H.A., and was submitted to support the contention that the Claimant is more than occasionally incontinent. This letter indicates that the PAS was marked incorrectly because the Nursing Assistant flow sheets reflect independent status with continence which declaration was made because Mr. ____ attended to changing his own undergarments as a measure of dignity and pride and did not seek staff assistance with this function.

8) Sworn testimony presented at the hearing, in conjunction with the evidence included in exhibit C-1 confirms that the Claimant was totally incontinent of bladder at the time of the assessment.

9) West Virginia Income Maintenance Manual, Chapter 17.11.B.1Before payment for nursing facility services can be made, medical necessity must be established. The PAS-2000 is used for this purpose. The PAS-2000 is signed by a physician and is evaluated by a medical professional of the State's contracted level of care evaluator. The PAS-2000 is valid for 60 days from the date the physician signs the form. The 60-day validity period applies, regardless of the reason for completion, i.e., new admission, transfer to a different facility. See item C below for situations when a PAS-2000 is not completed and payment for nursing facility care is requested for a prior period.

10) West Virginia Medicaid Manual Section 508.2 states, in part:

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 facility benefit. These deficits may be any of the following:

- Decubitus – Stage 3 or 4

- Unable to vacate a building – a person is physically unable at all times, requiring one-person assistance with walking (Item 25i) or mentally incapable of leaving the building due to total disorientation, with a diagnosis of dementia, alzheimers, or related condition (Items 25g and 33).

- The individual needs hands-on assistance with eating, bathing, grooming, dressing, transferring and walking.

- The individual is totally incontinent of bowel or bladder. Total incontinence is when the individual has no control of bowel or bladder functions at any time.

- The individual is totally disoriented to time and place or is comatose

- The individual cannot navigate a wheel chair in the home and must not be able to walk in the home without physical assistance.

- The individual has skilled nursing care needs in one or more of these areas: suctioning, tracheostomy, ventilator, parenteral fluids, sterile dressings or irrigations.

- The individual is not capable of administrating his/her own medications.

The assessment tool designated by the Bureau for Medical Services must be completed, 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.

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 of individuals applying for the Medicaid benefit. The PAS is completed and forwarded to the Bureau of Medical Services or its designee (WVMI) for medical necessity review. An individual must have a minimum of five (5) deficits identified on the PAS in order to qualify for the Medicaid nursing facility benefit. Policy goes on to say - 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.

2) The PAS assessment completed on the Claimant identified four (4) Program qualifying deficits – Bathing, Dressing, Grooming and Medication Administration. Testimony and documentation presented at the hearing establishes that the Claimant had a deficit in bladder incontinence (totally incontinent) when the medical assessment was completed. However, because eligibility can only begin when the latest of the three eligibility requirements are met, in this case the date the PAS was signed by the physician, eligibility for participation in the Medicaid Long-Term Care Program begins effect December 28, 2005.

3) While policy states that a Medicaid eligible individual cannot be charged for the cost of care during the non-covered period when the nursing facility fails to obtain an approved assessment prior to admission, this Hearing Examiner does not have the authority to rule on nursing facility charges incurred prior to the establishment of Medicaid eligibility (December 28, 2005).

IX. DECISION:

After reviewing information presented during the hearing and the applicable policy and regulations, it is the ruling of the State Hearing Officer to **reverse** the Agency's decision to deny medical eligibility for the Medicaid Long-Term Care Program. Medical eligibility begins effective December 28, 2005.

X. RIGHT OF APPEAL

See Attachment.

XI. ATTACHMENTS

The Claimant's Recourse to Hearing Decision.

Form IG-BR-29.

ENTERED this 29th day of June 2006,

_____

Thomas E. Arnett
State Hearing Examiner