State of West Virginia
**DEPARTMENT OF HEALTH AND HUMAN RESOURCES**
Office of Inspector General
Board of Review
150 Maplewood Avenue
Lewisburg, WV 24901

**Joe Manchin III**
**Governor**

**Martha Yeager Walker**
**Secretary**

**November 7, 2007**

_____
_____
_____
_____

Dear Ms. _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held October 23, 2007. Your hearing request was based on the Department of Health and Human Resources' decision to deny your medical eligibility 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. 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. (BMS Policy Manual Section 508.2)

Information submitted at the hearing revealed that your medical evaluation did require 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 Department=s determination that you are medically ineligible for the Medicaid Long-Term Care Program.

Sincerely,

Margaret M. Mann
State Hearing Officer
Member, State Board of Review

cc: Chairman, Board of Review
Nora McQuain, RN, Bureau for Medical Services, DHHR
Oretta Keeney, WVMI
[redacted] Administrator, [redacted] Center
_____, MPOA

**WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES**

**_____,**

**Claimant,**

**vs.** **Action Number 07-BOR-2106**

**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 October 23, 2007 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 on October 23, 2007 on a timely appeal filed September 5, 2007.

It should be noted here that the Claimant has been found medically ineligible for the Medicaid Long-Term Care Program.

## 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
_____, MPOA
_____, Claimant's Niece
[redacted] LPN, [redacted] Center
[redacted] Director of Nursing, [redacted] Center
Nora McQuain, RN, Director of Facilities and Residential Care, BMS, DHHR (participating telephonically)

Presiding at the hearing was Margaret M. Mann, State Hearing Officer 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:

Bureau for Medical Services Policy Manual Sections 508 & 508.2

## VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

**Department's Exhibits:**
D-1 Bureau for Medical Services 508, 508.1 and 508.2
D-2 Results of medical review by West Virginia Medical Institute (WVMI) – West Virginia Department of Health and Human Resources Pre-Admission Screening (PAS) dated 07/30/2007
D-3 West Virginia Medical Institute Notice of Denial for Long Term Care Admission Letter dated 08/08/2007

## VII. FINDINGS OF FACT:

1) A PAS medical evaluation (Exhibit D-2) was completed for the Claimant July 30, 2007 to determine medical eligibility for the Medicaid Long-Term Care Program. It was determined that the Claimant, who currently resides at [redacted] Center, is medically ineligible for the Medicaid Long-Term Care Program.

2) The Claimant was notified of the denial of long-term care services in a letter dated August 20, 2007. (Exhibit D-3) It was found that the Claimant had deficiencies in four (4) areas. Those were needs physical assistance with bathing, grooming, dressing and unable to administer medications.

3) Testimony from BMS RN NM revealed that along with the PAS there was medical information attached from White Sulphur Springs Center. (Exhibit D-2) The Monthly Summary dated 06/28/2007 reads in part that the Claimant (#1) ambulates with a cane or crutch, (#8) bladder: continent, (#10) briefs not used, (#11) feeds self, (#19) grooming: self-care, and (#20) hygiene: shower. The Monthly Summary dated 07/22/2007 is basically the same as the summary dated 06/28/2007. (Exhibit D-2) The Activities of Daily Living Flow Chart for August 2007 (Exhibit D-2) shows that the Claimant is independent for eating, has partial bath/shower under bathing, is independent under dressing, oral hygiene, ambulation, bed mobility, toileting – independent and continent bladder/bowel, does her own peri-care, and has range of motion. The information about dressing and grooming (oral hygiene) shows that the Claimant is independent and contradicts what was sent in on the PAS. It is noted under #4 Mental Status that the Claimant is alert and confused.

4) The items contested on the PAS were the Claimant's physical ability to vacate in the event of the emergency, eating, bowel incontinence, and orientation.

5) Testimony from NF revealed that she does not feel the Claimant could physically vacate in the event of an emergency. She would not know how to vacate and she does not think her legs would get her out

without a wheelchair. The Claimant is disoriented. The Claimant can eat on her own only because the food is brought to her. Prior to coming to the facility, she was hospitalized twice for bleeding ulcers. She was taking medication and her stomach was not coated enough to prevent bleeding. Her doctor at the time felt it was because the Claimant was not eating enough. Without assistance, she would not be eating properly. She can bathe herself to a point. Until NF forced the issue, her feet were not being washed. She now gets baths twice a week to ensure she is bathed properly. Her grooming and dressing are ok. Bladder continence is ok but she does have a bowel problem. NF does her laundry every week and has to throw away some of her underwear and buy new. She has a bleeding problem and her underwear and pajamas will have blood on them. Orientation – the Claimant is very confused. One can ask her five minutes after breakfast what she has had and she cannot tell you. She cannot tell you who has been to see her. She can carry on a conversation but will not remember the conversation. The Claimant does walk around her bed to the bathroom with a cane. She is very weak and suffered two falls at the facility in the past year. Most of the time if she goes very far in the facility a wheelchair is used.

6) Testimony from SB, LPN, revealed that the Claimant needs assistance with grooming. One has to go in and tell her it is time to get up, get her up, get her clothes ready, and a lot of times you have to make her do it. You have to send her to the bathroom to do her ADLs. She does not feel the Claimant is mentally of physically able to vacate in the event of a fire. The Claimant is on oxygen and one would have to show her where to go. If she has to go long distances, she has to be placed in a wheelchair and staff have to take her. She is incontinent at times (not all of the time).

7) Testimony from AW revealed the Claimant's condition has changed and she needs her wheelchair more. She cannot push herself in the wheelchair because she does not have the mental capability to do that. In regard to continence, the Claimant oftentimes will put her dirty clothes back on. She cannot dress herself without assistance. She would have to be physically pushed in order to get out of the building in the event of an emergency. You could not tell her where to go.

8) Testimony from the Claimant's witnesses revealed that it is their contention that the Claimant's actual condition and what is noted on the PAS and medical forms submitted for WVMI's review is different.

9) Diagnoses listed on the PAS (Exhibit D-2) are DM, HTN, CHE, GERD, aortic aneurysm, CAD, depression, anemia, osteoarthritis, and dementia.

10) Section 508 of the Bureau for Medical Services Policy Manual reads in part that 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 information. The determination must occur prior to payment for services. The date the benefit starts is the later of one of the following dates: 1) The date of application in the local DHHR office; 2) 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.

11) Bureau for Medical Services Policy 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 nursing facility benefit. These deficits may be any of the following:

- #24 Decubitis- 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 The individual has skilled nursing care needs in one or more of these areas: suctioning, tracheostomy, ventilator, parenteral fluids, sterile dressings or irrigations.
- Individual is not capable of administrating 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.

## 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 (PAS) 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. Evidence reveals that a PAS was completed on July 30, 2007 and it was determined that the Claimant is medically ineligible for Medicaid Long-Term Care Services.

2) Policy holds that to medically qualify for the nursing home Medicaid benefit, an individual must have a minimum of five (5) qualifying deficits on the PAS. These deficits are derived from a combination of assessment elements on the medical evaluation. The Claimant's PAS revealed that she has four (4) qualifying deficits. These are that she needs physical assistance with bathing, grooming and dressing and is unable to administer her medications.

3) There was conflicting information in the medical records and the information on the PAS. However, the WVMI reviewer determined that the Claimant needs physical assistance with bathing, grooming and dressing and is unable to administer medications.

4) Those testifying on behalf of the Claimant addressed the following deficits: eating, bowel incontinence, orientation, and the Claimant's physical/mental ability to vacate in the event of an emergency.

5) BMS Policy 508.2 specifies under functional abilities that one must need physical assistance to get nourishment in order to receive a deficit for eating. Documentation shows that the Claimant can feed herself. No additional deficit will be awarded for eating.

6) BMS Policy 508.2 specifies under functional abilities that one must be totally incontinent in order to be awarded a deficit for bowel incontinence. The documentation and testimony does not support this finding; therefore, no additional deficit will be awarded for bowel incontinence.

7) BMS Policy 508.2 specifies under functional abilities that one must be totally disoriented or comatose in order to be awarded a deficit for orientation. The documentation and testimony does not support this finding, therefore, no additional deficit will be awarded for orientation.

8) BMS Policy 508.2 specifies that in order to receive a deficit for vacating, the individual must be mentally unable or physically unable to vacate in the event of an emergency. Testimony and evidence at the hearing shows that the Claimant is confused, ambulates with a cane and if going a long distance, a wheelchair must be used. It is the finding of the State Hearing Officer that the Claimant is mentally unable to vacate in the event of an emergency. An additional deficit will be awarded for vacating.

9) The Claimant has a total of five deficits. The Department's conclusion that the Claimant is medically ineligible for the Medicaid Long-Term Care Program is incorrect.

## IX. DECISION:

It is the ruling of the State Hearing Officer to reverse the Department's decision to deny medical eligibility for the Medicaid Long-Term Care Program.

## X. RIGHT OF APPEAL

See Attachment.

## XI. ATTACHMENTS

The Claimant's Recourse to Hearing Decision.

Form IG-BR-29.

**ENTERED this 7th day of November, 2007.**

**Margaret M. Mann**
**State Hearing Officer**

# THE CLAIMANT'S RECOURSE TO HEARING DECISION

## A. CIRCUIT COURT

An adverse decision of a State Hearing Officer is subject to judicial review through a Writ of Certiorari (West Virginia Code 53-3-1 et seq.) filed in the Circuit Court of Kanawha County within four (4) months from the date of the hearing decision.

The court may determine anew the decision or determination of the State Hearing Officer. In such appeals a certified copy of the hearing determination or decision is admissible or may constitute prima facie evidence of the hearing determination or decision. Furthermore, the decision may be appealed to the Supreme Court of Appeals of the State of West Virginia.

## B. THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against because of race, color, national origin, age, sex or handicap, write immediately to the Secretary of the United States Department of Health and Human Services, Washington, D.C. 20201.

## C. THE UNITED STATES DEPARTMENT OF AGRICULTURE

If the hearing decision involves food stamps and you believe you have been discriminated against because of race, color, national origin, age, sex or handicap, write immediately to the Secretary of the Department of Agriculture, Washington, D.C. 20250.