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

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

October 20, 2008

_____
_____
_____
_____

RE: _____ **Case No. 08-BOR-1793**

Dear _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held October 14, 2008. Your hearing request was based on the Department of Health and Human Resources' action to deny your application for Medicaid Long-Term Care (Nursing Facility) benefits.

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 Medicaid, Long Term Care (Nursing Facility) Services is based on current policy and regulations and 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 (PAS) form 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 requires a sufficient number of services and the degree of care necessary to medically qualify you for nursing facility level of care.

It is the decision of the State Hearing Officer to **uphold** the Department's action in denying your application for Medicaid Long-Term Care benefits based on medical eligibility criteria.

Sincerely,

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

Pc: Erika H. Young, Chairman, Board of Review
Michael Bevers, Esq., Assistant AG's Office

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

_____,

Claimant,

v. **Action Number: 08-BOR-1793**

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 concluded on October 20, 2008 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 October 14, 2008 on a timely appeal filed August 7, 2008.

II. PROGRAM PURPOSE:

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

Long-Term Care is a medical service covered by the State's Medicaid Program. Payment for care is made to nursing homes that meet Title XIX standards for the care provided to eligible recipients. In order to qualify for Long-Term Care (Nursing Facility) benefits, an individual must meet both financial and medical eligibility criteria.

III. PARTICIPANTS:

_____, Counsel for Claimant
_____, Claimant's daughter
Dr. _____, Forensic Psychiatrist
Dr. _____, Psychologist
Michael Bevers, Esq., Assistant AG's Office, Counsel for the Department
Kelly Johnson, Program Manager, Long-Term Care Program
Stacy Holstine, RN, Project Manager, 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(s) to be decided is whether the Department was correct in determining that the Claimant fails to meet the medical eligibility criteria for participation in the Medicaid Long-Term Care (Nursing Facility) Program.

V. APPLICABLE POLICY:

West Virginia Medicaid Manual, Chapter 500, Section 514
Code of Federal Regulations 42 CFR §§ 483.126, 483.128, & 483.130

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

Exhibit 1	West Virginia Medicaid Manual, Chapter 500, Section 514 (pages 1-3)
Exhibit 2	Pre-Admission Screening (PAS) form, dated June 23, 2008 (pages 4-9)
Exhibit 3	Notice of Denial Determination by WVMI dated June 24, 2008 (pages 10 & 11)
Exhibit 4	Supporting Documentation (pages 12-20)
Exhibit 5	Letter from _____, MA, to [redacted] Hospital with attachments (pages 21-26)
Exhibit 6	Not entered

Claimant's Exhibits:

Claimant's Exhibit 1	Correspondence electronically signed by _____, Ph.D., ABBP-cn, Professor; [redacted]
Claimant's Exhibit 2	Discharge Summary from [redacted] Hospital, electronically signed by _____, MD, Resident, [redacted] and _____, MD, Professor, [redacted]

VII. FINDINGS OF FACT:

1) On June 24, 2008, the Claimant was notified that her application for Medicaid Long-Term Care benefits was denied (Exhibit 3). This notice states, in pertinent part:

> **NOTICE:** 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 WVMI on the Pre-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 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 2 areas identified below – Vacate a Building and Administering Medications.

2) Evidence presented at the hearing reveals that the Claimant has been in and out of mental health and nursing facilities her entire adult life. She was most recently a resident at [redacted] Center, a nursing facility in [redacted] WV, since October 2004, but required hospitalization to stabilize her medical condition. In order for the Claimant to reenter the nursing facility, a new Pre-Admission Screening (PAS) form was completed (Exhibit 2) on June 23, 2008.

3) The Department cited Medicaid regulations (Exhibit 1) and called its witness to explain how Medicaid policy was applied to the medical findings documented on the Claimant's PAS (Exhibit 2). According to the Department's witness, the Claimant's treating physician(s) completed the medical assessment and this documentation was relied upon by WVMI to identify qualifying deficits. The Department noted that documentation from [redacted] Center - Minimum Data Set (MDS), MDS ADL Report, as well as Nursing Notes (see Exhibit 4) - were reviewed and these documents are consistent with the medical findings on the Claimant's PAS. The Department noted that Section #41 (Medical Eligibility Determination) of the PAS (Exhibit 2, page 9, also see Exhibit 5, page 23) indicates the evaluating physician marked letter "c" – No Services Needed.

4) The Claimant, by counsel, contends that a Level II evaluation (evaluation required for individuals with Mental Illness and/or Mental Retardation) was completed by Dr. _____, Ph.D., on June 30, 2008 (see Exhibit 5, Page 23, Section #43), and the determination was made that - "Nursing facility services needed – specialized services not needed." In Section #44 (Recommended Placement), _____ recommends Nursing Facility Services/Aged & Disabled Waiver.

Dr. _____ and _____ have completed mental assessments on the Claimant and presented testimony to indicate that while she has mental illness, she would best be served in a nursing facility setting that provides 24-hour care and supervision. Counsel for the Claimant presented Claimant's Exhibits 1 and 2 to further demonstrate that every physician who has been involved with the Claimant has recommended nursing facility care.

Counsel for the Claimant further contends that the United States Code, found at 42 U.S.C. 1396 (e) (c) (I), requires that a Level II evaluation be completed and considered for placement in a nursing facility when an individual has mental illness. The Claimant further contends that subparagraph (b) of the 42 U.S.C. 1396 (e) (c) (I) states in the case of a resident who has been determined to not require the level of services provided by a nursing facility, but to require specialized services for mental illness, and who has continuously resided in a nursing facility for at least 30 months before the date of determination, the state must, in consideration with the resident's family, offer the resident a choice of remaining in the nursing facility or of receiving covered services in an alternative appropriate institutional or noninstitutional setting. It should be noted that while 42 U.S.C. 1396 (e) was located, it is not pertinent to the matter at hand. The regulations cited by the Claimant are located at 42 CFR §§ 483.128 & 483.130.

5) The Department contends that the medical eligibility screening process is a two-step process. The Level I process determines medical eligibility only. If the individual is determined to be medically eligible for a nursing facility (NF) level of care, and the individual presents a diagnosis of MI or MR, the individual must undergo a Level II evaluation to determine if placement in a nursing facility is appropriate. However, the Department contends that a Level II evaluation is not completed during the Long-Term Care eligibility screening process if the individual does not meet nursing facility medical eligibility requirements at Level I. The Department contends that a Level II evaluation should not have been completed on the Claimant and that medical eligibility can only be certified by a Medical Doctor (MD) or Doctor of Osteopathy (DO). While _____ is qualified to recommend that nursing facility placement is appropriate for an individual with MI or MR, the individual must first meet the medical criteria.

6) WV DHHR Medicaid, Long Term Care Policy §514.8 (Exhibit 1), 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:
>
> - 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.

514.8.1 APPLICATION PROCEDURE

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.

7) The Code of Federal Regulations, 42 CFR §483.126, addresses "appropriate placement" of individuals with MI or MR in a nursing facility and states - Placement of an individual with MI or MR in a NF may be considered appropriate only when the individual's needs are such that he or she meets the minimum standards for admission and the individual's needs for treatment do not exceed the level of services which can be delivered in the NF to which the individual is admitted either through NF services alone or, where necessary, through NF services supplemented by specialized services provided by or arranged for by the State.

8) The Code of Federal Regulations provides PASARR evaluation criteria - Level I, at 42 CFR §483.128 (a), and states: Identification of individuals with MI or MR. The State's PASARR program must identify all individuals who are suspected of having MI or MR as defined in Sec. 483.102. This identification function is termed Level I. Level II is the function of evaluating and determining whether NF services and specialized services are needed. The State's performance of the Level I identification function must provide at least, in the case of first time identifications, for the issuance of written notice to the individual or resident and his or her legal representative that the individual or resident is suspected of having MI or MR and is being referred to the State mental health or mental retardation authority for Level II screening.

9) 42 CFR §483.128 (e) – PASARR evaluation criteria, states: The State's PASARR program must use at least the evaluative criteria of sec. 483.130 (if one or both determinations can easily be made categorically as described in sec. 483.130) or of sec. sec. 483.132 and 483.134 or sec. 483.136 (or, in the case of individuals with both MI and MR, sec. sec. 483.132, 483.134 and 483.136 if a more extensive individualized evaluation is required).

10) The Code of Federal Regulations sets forth placement options for individuals with MI and MR at 42 CFR § 483.130.

> (m) Placement options. Except as otherwise may be provided in an alternative disposition plan adopted under section 1919(e)(7)(E) of the Act, the placement options and the required State actions are as follows:
>
> (1) Can be admitted to a NF. Any applicant for admission to a NF who has MI or MR and who requires the level of services provided by a NF, regardless of whether specialized services are also needed, may be admitted to a NF, if the placement is appropriate, as determined in Sec. 483.126. If specialized services are also needed, the State is responsible for providing or arranging for the provision of the specialized services.
>
> (2) Cannot be admitted to a NF. Any applicant for admission to a NF who has MI or MR and who does not require the level of services provided by a NF, regardless of whether specialized services are also needed, is inappropriate for NF placement and must not be admitted.
>
> (3) Can be considered appropriate for continued placement in a NF. Any NF resident with MI or MR who requires the level of services provided by a NF, regardless of the length of his or her stay or the need for specialized services, can continue to reside in the NF, if the placement is appropriate, as determined in Sec. 483.126.
>
> (4) May choose to remain in the NF even though the placement would otherwise be inappropriate. Any NF resident with MI or MR who does not require the level of services provided by a NF but does require specialized services and who has continuously resided in a NF for at least 30 consecutive months before the date of determination may choose to continue to reside in the facility or to receive covered services in an alternative appropriate institutional or noninstitutional setting. Wherever the resident chooses to reside, the State must meet his or her specialized services needs. The determination notice must provide information concerning how, when, and by whom the various placement options available to the resident will be fully explained to the resident.

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. 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 evaluating physician. The Code of Federal Regulations states that placement of an individual with MI or MR in a NF may be considered appropriate only when the individual's needs are such that he or she meets the minimum standards for admission.

2) The medical eligibility determination (Level I assessment) was uncontested and the Claimant demonstrates two (2) program qualifying deficits – Vacate a building and Administering Medications. Pursuant to Medicaid eligibility criteria, the Claimant is not medically demonstrating the need for a nursing facility level of care. With regard to the Claimant's argument that she should be provided the option to stay in a nursing facility based on 30 consecutive months of residency, the Code of Federal Regulations states this is only applicable for individuals who require specialized services. As noted in FOF #4, _____'s Level II evaluation of the Claimant determined that specialized services were not needed.

3) Pursuant to Medicaid policy and the Notice of Denial Determination, Medicaid funding requires an eligible individual to demonstrate five (5) qualifying deficits. Because the Claimant demonstrates only two (2) deficits, medical eligibility for Medicaid funding through the Medicaid Long-Term Care Program cannot be established.

IX. DECISION:

It is the decision of the State Hearing Officer to **uphold** the Department's action in denying the Claimant's application for Medicaid Long-Term Care (Nursing Facility) benefits.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 20th Day of October, 2008.

_____

Thomas E. Arnett
State Hearing Officer