State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
9083 Middletown Mall
White Hall, WV 26554

Joe Manchin III
Governor

Patsy A. Hardy, FACHE, MSN, MBA
Cabinet Secretary

December 4, 2009

-----for

Dear -----:

Attached is a copy of the findings of fact and conclusions of law on your hearing held October 29, 2009. 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
Lorna Harris, BMS

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

-----,

Claimant,

v. **Action Number: 09-BOR-1623**

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 December 4, 2009 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 convened October 29, 2009 on a timely appeal filed August 7, 2009.

II. PROGRAM PURPOSE:

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:

-----, Claimant's daughter/ POA/MPOA
-----, MSW, Program Manager, Long-Term Care Program - (Participated telephonically)
Joyce Romeo, RN, West Virginia Medical Institute (WVMI) - (Participated telephonically)

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 to be decided is whether or not the Department was correct in determining 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

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

Exhibit-1	Nursing Facility Manual, Chapter 514, 514.8.1, 514.8.2 – Pages 1-3
Exhibit-2	Pre-Admission Screening (PAS) – Pages 4-9
Exhibit-3	Notice of Denial Determination by WVMI – Page 10
Exhibit-4	Supporting Documentation – Pages 11-22
Exhibit-5	Information received from ---- – Pages 23-82

Claimant's Exhibits:

Claimant's-1	Imaging Results 7/28/09, XR Chest PAD and Lateral 7/24/09 & CAT Scat Results from August 28, 2008
Claimant's-2	Medical Record (Progress Notes) dated 3/18/09
Claimant's-3	Medical Record (Progress Notes) dated 4/22/09
Claimant's-4	Medical Record (Progress Notes) dated 9/23/09
Claimant's-4a	Medical Record (Progress Notes) dated 9/23/09
Claimant's-4b	[redacted] Hospitals, Discharge Note, discharge date 8/19/09
Claimant's-5	Progress Notes (Department of Behavioral Medicine and Psychiatry) dated 7/27/09
Claimant's-6	Section IV (Physician Recommendation) of the PAS completed on 7/24/09 (Duplicate of Department's Exhibit 2, page 8)
Claimant's-7	Medical Record (Progress Notes) dated 8/17/09
Claimant's-8	Correspondence from [redacted] Health Care, [redacted] MD, dated 8/11/09
Claimant's-8a	Medical Record documentation from [redacted] MD dated 7/15/09
Claimant's-9	MRI Spine Lumbosacral W/WO Contrast – report date 1/30/09
Claimant's-10	Electromyogram Report dated 3/4/09
Claimant's-11	Report of Operation [redacted] General Hospital) dated 6/24/09
Claimant's-12	Medical Record (Progress Notes) dated 12/30/08
Claimant's-12a	Consultation dated 12/30/08
Claimant's-12b	Consultation Report dated 5/7/09
Claimant's-12c	Medical Record (Progress Notes) dated 5/6/09

Claimant's-13	Information about Claimant's Hypertensive Retinopathy accompanied by Medical Records (Progress Notes) from the [redacted] Eye Clinic
Claimant's-13a	Correspondence from [redacted] OD, dated 10/8/09
Claimant's-14	Consultation and Medical Record (Progress Notes) dated 12/30/08
Claimant's-15	Medical Record (Progress Notes) Primary Care Visit dated 9/23/09
Claimant's-16	Report of Operation [redacted] General Hospital) dated 6/17/98
Claimant's-17	Report of Operation [redacted] General Hospital) dated 12/13/04
Claimant's-17a	Medical Record (Progress Notes) [redacted] Pain Clinic 9/12/01 – 7/18/08
Claimant's-18	CT of the Brain (Final Report) dated 12/30/08
Claimant's-19	Claimant's reported monthly income/costs and resulting deficit
Claimant's-20	United World Life Insurance Explanation of Benefits – Charges submitted for payment – statement dates are 9/8/09 to 9/18/09
Claimant's-21	West Virginia Health Care Association 6/11/09, CEO Notes, accompanied by *Shank v. West Virginia Department of Health and Human Resources and West Virginia Medical Institute*
Claimant's-22	[redacted] Manor Invoice for September and October with a copy of checks reportedly used to pay the invoice.
Claimant's-23	Information/documentation from ----- personal diaries pertaining to the Claimant.
Claimant's-24	To Whom it May Concern from -----(undated).
Claimant's-25	[redacted] Diary 8/19/09 – 10/21/09
Claimant's-26	General Power of Attorney appointing -----
Claimant's-27	Combined Medical Power of Attorney and Living Will assigning -----

VII. FINDINGS OF FACT:

1) On July 27, 2009, the Claimant was notified that his 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) 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 physician completed the medical assessment and this documentation was relied upon by WVMI to identify qualifying deficits. As a result, the Department witness testified the Claimant is demonstrating only two deficits – vacate a building and administration of medication. The Department maintains that the Claimant is not demonstrating the need for a nursing facility (NF) level of care. A Level II evaluation was recommended on the PAS, however, a Level II evaluation was not completed due to a finding of medical ineligibility.

3) The Claimant's representative, -----, submitted exhibits Claimant's-1 through Claimant's-27 to demonstrate that her father has a history of both medical and mental impairments. The Claimant's representative acknowledged that while the Claimant is only demonstrating two functional deficits as defined on the PAS, his mental illness (short and long-term m----- impairment related to severe dementia, depression and threats of suicide) as well as his financial plight should be considered. The Claimant's representative cited *Shank v. West Virginia Department of Health and Human Resources and West Virginia Medical Institute* wherein she contends that the Circuit Court in Kanawha County ruled that an individual can be determined eligible for a nursing facility level of care on the basis of their mental impairment. Claimant's 7, 8 and 8a includes documentation from [redacted] MD, and [redacted] MD, and both physicians indicate the Claimant is unable to safely live independently and Dr. [redacted] opinion is that the Claimant is a candidate for a dementia unit in a nursing home. It should be noted that recommendations from both physicians (Claimant's-7 and 8) occurred subsequent to the PAS completed in July 2009. -----contends that the Claimant continues to have difficulty with walking and falling, however, there is no clinical documentation to support this contention. She indicates that he now requires assistance with bathing, although this development, according to -----, has occurred subsequent to the PAS. -----further testified that he has experienced "bouts of diarrhea" which have resulted in him soiling himself and requiring clean-up, however, there is no clinical evidence to indicate he suffers from bowel incontinence. -----testified that while her father is currently placed in [redacted] Village Assisted Living, neither her father nor her family can afford to keep him there. As a result, she is further asking that expenses paid by her to [redacted] Village, in the amount of $4,314.50, be reimbursed as she contends the PAS should have been approved.

4) 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.

5) The Code of Federal Regulations, 42 CFR §483.126, addresses "appropriate placement" of individuals with MI or MR in a nursing facility and states - <u>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</u> [emphasis added] 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.

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. As a matter of record, the Claimant's representative acknowledged the Claimant is not demonstrating five (5) functional deficits but contends the Claimant's mental illness is consistent with the court ruling in the case *Shank v West Virginia Department of Health and Human Resources and West Virginia Medical Institute*, and therefore he should be found eligible for a nursing facility level of care. However, the Court's ruling in the Shank case does not set legal precedent, and the evidence demonstrates (with the exception of vacating and administering medications) that the Claimant required only prompting and supervision with his activities of daily living (ADL) when the PAS was completed in July 2009.

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, eligibility for 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 4th Day of December, 2009.

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Thomas E. Arnett
State Hearing Officer