State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
4190 Washington Street, West
Charleston, WV 25313

Joe Manchin III
Governor

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

August 26, 2010

Dear -----:

Attached is a copy of the findings of fact and conclusions of law on your hearing held August 25, 2010. Your hearing request was based on the Department of Health and Human Resources' action to deny your medical eligibility for Nursing Facility care.

In arriving at a decision, the State Hearings 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 know as the Pre-Admission Screening form (PAS) to be utilized for physician certification of the medical needs of individual apply 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.

The information submitted at your hearing reveals that your medical condition does require a sufficient number of services and the degree of care required to qualify you for Nursing Facility level of care.

It is the decision of the State Hearings Officer to **uphold** the Department's decision to deny your participation in the Medicaid Long-Term (Nursing Home) Care Program based on medical eligibility.

Sincerely,

Cheryl Henson
State Hearing Officer
Member, State Board of Review

cc: Erika H. Young, Chairman, Board of Review
Nora McQuain, BMS
Amy Workman, BMS

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

-----,

Claimant,

v. **Action Number: 08-BOR-1598**

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 conducted 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 August 25, 2010 on a timely appeal filed July 13, 2010.

It should be noted that the Claimant's benefits have been continued pending the outcome of this hearing.

II. PROGRAM PURPOSE:

The program entitled Long Term Care Medicaid (nursing facility services) 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 (Medicaid) standards for the care provided to eligible recipients. In order to qualify for Nursing Home Care, an individual must meet financial and medical eligibility criteria

III. PARTICIPANTS:

-----, Claimant
-----, Claimant's representative
-----, Claimant's representative

Nora McQuain, BMS, Department Representative

It should be noted that the Department participated by telephone conference call.

Presiding at the Hearing was Cheryl Henson, 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 Department was correct in determining that the Claimant fails to meet the medical eligibility criteria for participation in the Medicaid Long Term Care (Nursing Home) Program.

V. APPLICABLE POLICY:

West Virginia Nursing Facility Manual Sections 514.8.1 and 514.8.2

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 West Virginia Nursing Facility Policy Manual, Chapters §514.8.1 and 2
D-2 Pre-Admission Screening (PAS) completed June 16, 2010
D-3 Notice from WVMI dated June 30, 2010
D-4 Supporting documentation

Claimant's Exhibits:

None

VII. FINDINGS OF FACT:

1) On or about June 16, 2010 the Department sent the Claimant a notification letter (D-3) which included the following pertinent information:

> NOTE: YOUR REQUEST FOR LONG-TERM CARE (NURSING HOME) ADMISSION HAS BEEN DENIED.
>
> 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 areas identified below – Bathing and Administering Medications.

2) West Virginia (WV) Nursing Facility Policy Manual §514.8, (RESIDENT ELIGIBILITY REQUIREMENTS) states in pertinent part:

> 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.

APPLICATION PROCESS

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.

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.

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
- #24 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 individuals 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 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.

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 on 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.

3) In this situation, the Claimant's representative had requested that she be transferred to another facility, which caused the new medical assessment, which was completed in June 2010, to be necessary according to policy.

4) After listening to the Department's representative, Nora McQuain, explain the Department's policy which requires that five (5) deficits be established for eligibility, as well as her review of the PAS completed in June 2010 showing that the Claimant received two deficits during the assessment, the Claimant's representatives, ----- and -----, were unable to identify an additional three (3) deficits that they believe the Claimant should have been awarded at the time the PAS was completed.

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. 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.

2) The June 2010 PAS revealed that the Claimant received two (2) qualifying deficit in areas of Bathing and Administering Medications.

3) There was insufficient evidence presented during the hearing to support the award of three (3) additional deficits.

4) Whereas the Claimant is unable to show evidence to support that she exhibited five (5) deficits at the time the June 2010 PAS assessment was completed, the Department's decision to deny medical eligibility for Nursing Facility level of care is found to be correct.

IX. DECISION:

It is the decision of the State Hearing Officer to **uphold** the actions of the Department in denying the Claimant's medical eligibility for participation in the Medicaid Long-Term Care (Nursing Facility) Program.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 26th day of August, 2010.

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Cheryl Henson
State Hearing Officer