STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL

Earl Ray Tomblin
Governor

BOARD OF REVIEW
416 Adams St.
Fairmont, WV 26554

Karen L. Bowling
Cabinet Secretary

March 8, 2016

[redacted]

RE: [redacted] v. WVDHHR
ACTION NO.: 16-BOR-1268

Dear Ms. [redacted]

Enclosed is a copy of the decision resulting from the hearing held in the above-referenced matter.

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.

You will find attached an explanation of possible actions you may take if you disagree with the decision reached in this matter.

Sincerely,

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

Encl: Appellant's Recourse to Hearing Decision
Form IG-BR-29

cc: Angela Signore/Kelley Johnson, BMS
[redacted], [redacted]

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 16-BOR-1268**

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES,

Respondent.

DECISION OF STATE HEARING OFFICER

INTRODUCTION

This is the decision of the State Hearing Officer resulting from a fair hearing for [redacted]. This hearing was held in accordance with the provisions found in Chapter 700 of the West Virginia Department of Health and Human Resources' Common Chapters Manual. This fair hearing was convened on March 8, 2016, on an appeal filed February 4, 2016.

The matter before the Hearing Officer arises from the January 25, 2016 decision by the Respondent to deny the Appellant's application for Medicaid Long-Term Care benefits due to an unfavorable medical eligibility determination.

At the hearing, Respondent appeared by Kelley Johnson, Program Manager for the Bureau for Medical Services. Appearing a witness for the Respondent was [redacted], RN, APS Healthcare. The Appellant was represented by [redacted], Appellant's Medical Power of Attorney (MPOA). Appearing as a witness for the Appellant was [redacted], LSW, [redacted]. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

- D-1 Bureau for Medical Services Medicaid Provider Manual §514.6 (Page 1)
- D-2 Pre-Admission Screening (PAS) form dated 1/20/16 (Pages 2-8)
- D-3 Notice of Denial for Long-Term Care (Nursing Home) dated 1/25/16 (Page 9)
- D-4 Physician's determination of Capacity dated 1/4/16 (Page 10)
- D-5 Documentation submitted by [redacted] physician (Pages 11-47)

After a review of the record, including testimony, exhibits, and stipulations admitted into evidence at the hearing, and after assessing the credibility of all witnesses and weighing the evidence in consideration of the same, the Hearing Officer sets forth the following Findings of Fact.

FINDINGS OF FACT

1) On January 20, 2016, Appellant was evaluated to determine medical eligibility for participation in the Medicaid Long-Term Care Program. The Pre-Admission Screening (PAS) form (D-2) was signed by [redacted], MD, and identified four (4) functional deficits.

2) On or about January 25, 2016, Respondent issued notice (D-3) to Appellant of its decision to deny her application for Medicaid Long-Term Care Program benefits as a result of the determination that she did not meet medical eligibility criteria – five (5) functional deficits were not identified.

3) As a matter of record, Respondent stipulated that the Appellant demonstrated four (4) functional deficits in the following areas – medication administration, grooming, bathing and dressing.

4) In response to Appellant contending that a deficit should have been awarded in the functional area of transferring, Respondent acknowledged that additional documentation (D-5, page 21) affirms that a fifth (5^{th}) deficit (transferring) was identified.

APPLICABLE POLICY

According to the West Virginia Bureau for Medical Services Medicaid Provider Manual §514.6.3, to qualify medically for the nursing facility Medicaid benefit, an individual must need direct nursing care 24 hours a day, 7 days a week. BMS has designated a tool known as the Pre-Admission Screening form (PAS) (see appendix II) 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 deficits identified on the PAS. These deficits will be determined based on the review by BMS/designee 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 the 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. Department of Health and Human Resources Chapter 514: Nursing Facility Services Page 30 January 1, 2013 DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

- #27: Individual has skilled needs in one 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.

This assessment tool must be completed, signed and dated by a physician. The physician's signature indicates "to the best of my knowledge, the patient's medical and related needs are essentially as indicated". It is then forwarded to the Bureau or their designee for medical necessity review. The assessment tool must be completed and reviewed for every individual residing in a nursing facility, regardless of the payment source for services.

DISCUSSION

According to the West Virginia Bureau for Medical Services Medicaid Provider Manual §514.6.3, to qualify medically for the nursing facility Medicaid benefit, an individual must need direct nursing care 24 hours a day, 7 days a week. The PAS is utilized for physician certification of medical needs and must identify a minimum of five (5) deficits in order to qualify for the Medicaid nursing facility benefit. As a matter of record, both parties agreed that the findings on the PAS, considered in conjunction with the additional documentation submitted by [redacted], confirms that the Appellant qualifies for the nursing facility Medicaid benefit - five (5) functional deficits have been identified.

CONCLUSIONS OF LAW

The evidence confirms that the Appellant was demonstrating five (5) functional deficits when the January 2016 PAS was completed. As a result, medical eligibility for participation in the Medicaid Long-Term Care Program is established.

DECISION

It is the decision of the State Hearing Officer to REVERSE Respondent's action to deny Appellant's application for Medicaid Long-Term Care Program benefits based on an unfavorable medical eligibility determination.

ENTERED this ____Day of March 2016.

_____

Thomas E. Arnett
State Hearing Officer