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

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M. Katherine Lawson
Inspector General

August 23, 2018

[redacted]

RE: [redacted] v. WV DHHR
ACTION NO.: 18-BOR-1877

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,

Todd Thornton
State Hearing Officer
Member, State Board of Review

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

cc: Angela Signore, DHHR / Kelley Johnson, DHHR
[redacted], Appellant Representative

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Appellant,

v. Action Number: 18-BOR-1877

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 July 26, 2018, on an appeal filed June 13, 2018.

The matter before the Hearing Officer arises from the May 31, 2018 decision by the Respondent to deny the Appellant's application for Long Term Care/Nursing Facility Medicaid based on medical eligibility findings.

At the hearing, the Respondent appeared by Kelley Johnson. Appearing as a witness for the Department was Mary Casto. The Appellant appeared *pro se*. Appearing as witnesses for the Appellant were [redacted], [redacted], and [redacted]. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

D-1	BMS Provider Manual (excerpt) Chapter 514 Nursing Facility Services §§ 514.6 – 514.6.3
D-2	Pre-Admission Screening (PAS) form Assessment Date: May 21, 2018
D-3	Notice of Denial for Long-Term Care (Nursing Facility) Notice Date: May 31, 2018

D-4	Physician's Determination of Capacity Date signed: March 2, 2018
D-5	Minimum Data Set (MDS) documents Resident Assessment and Care Screening Assessment Date: June 1, 2018
D-6	Additional medical documentation submitted by the Appellant to the Respondent

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) The Appellant applied for Long Term Care (LTC) Medicaid for nursing facility services.

2) The Appellant was assessed to determine her medical eligibility for LTC Medicaid on May 21, 2018, and the findings from this assessment were documented on a Pre-Admission Screening (PAS) form. (Exhibit D-2)

3) The Respondent additionally considered the documentation from a Minimum Data Set (MDS) assessment of the Appellant completed June 1, 2018. (Exhibit D-5)

4) By notice dated May 31, 2018, the Respondent notified the Appellant that her LTC Medicaid application was denied due to an insufficient number of "area of care needs," or "deficits" to meet Medicaid policy requirements. The notice advised the Appellant that policy requires five such deficits meeting the severity criteria, and that the Appellant only established two – *bathing* and *vacating a building* in the event of an emergency. (Exhibit D-3)

5) The Appellant did not propose specific areas of care that should have been assessed as "deficits."

6) The Appellant did not establish any additional deficits than those awarded on the May 2018 PAS. (Exhibit D-2)

APPLICABLE POLICY

The Bureau for Medical Services Provider Manual, Chapter 514: Covered Services, Limitations, and Exclusions, for Nursing Facility Services, §514.6.3, details the medical eligibility determination process for LTC Medicaid, or Nursing Facility Services, as follows:

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. BMS 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
- #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.
- #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.

DISCUSSION

The Appellant has appealed the Respondent's decision to deny her application for LTC Medicaid, or Nursing Facility Services, based on insufficient deficits to establish medical eligibility. The Respondent must prove by a preponderance of the evidence that the Appellant did not establish medical eligibility for the program.

LTC Medicaid policy requires five deficits to establish medical eligibility. The PAS noted two deficits for the Appellant. Testimony and evidence failed to establish any additional deficits. The Appellant is presently residing in a nursing facility, and testimony from the Appellant's witnesses contended that this is the reason for the findings from the May 2018 PAS – the Appellant requires nursing facility care but thrives once she is in that setting to the point she no longer needs care, returns home and repeats this cycle. There is no provision in nursing facility Medicaid policy for speculatively assessing an individual's area of care needs.

Testimony established the Appellant fell while in the nursing facility approximately a month after her May 21, 2018 assessment, but there was no history of falls indicative of an incorrect assessment of the Appellant in the area of walking. The Appellant was assessed as independent in the area of walking on the May 2018 PAS (Exhibit D-2), and notes from the MDS (Exhibit D-

5) describe her ability to walk in the nursing facility as "setup help only," or one level below the "one person physical assist" designation that would correspond with the Level 3 described in policy as necessary for a deficit in walking. Testimony related to other areas described the Appellant in the past or speculated on how she would be assessed if she returns home.

The Respondent proved that its assessment of the Appellant's medical area of care needs, or deficits, was correct. The Respondent's action to deny the Appellant's application for LTC Medicaid based on fewer deficits than required by policy is affirmed.

CONCLUSION OF LAW

Because the Appellant did not meet the severity criteria in at least five (5) of the areas of care set by policy, the Respondent must deny the Appellant's application for LTC Medicaid for nursing facility services based on unmet medical eligibility.

DECISION

It is the decision of the State Hearing Officer to **uphold** the Respondent's decision to deny the Appellant's application for LTC Medicaid for nursing facility services.

ENTERED this ____Day of August 2018.

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Todd Thornton
State Hearing Officer