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

Jim Justice
Governor

BOARD OF REVIEW
416 Adams St.
Suite 307
Fairmont, WV 26554
304-368-4420 ext. 79326

Bill J. Crouch
Cabinet Secretary

January 10, 2018

[redacted]

RE: [redacted] v. WVDHHR
ACTION NO.: 17-BOR-2837

Dear Mr. [redacted]

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

In arriving at a decision, the Board of Review is governed by the Public Welfare Laws of West Virginia and the rules and regulations established by the Department of Health and Human Resources (DHHR). 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 that may be taken if you disagree with the decision reached in this matter.

Sincerely,

Tara B. Thompson
State Hearing Officer
State Board of Review

Enclosure: Appellant's Recourse to Hearing Decision
Form IG-BR-29
cc: Stacy Broce, Bureau for Medical Services
Angela Signore, Bureau for Medical Services
[redacted], Appellant relative

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Appellant,

v. ACTION NO.:17-BOR-2837

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 January 5, 2018, on an appeal filed November 8, 2017.

The matter before the Hearing Officer arises from the November 2, 2017 decision by the Department to deny the Appellant's application for Long-Term Care (LTC) Medicaid based on medical ineligibility.

At the hearing, the Respondent was represented by [redacted] (Nurse [redacted]), Review Nurse, KEPRO. The Appellant appeared *pro se*. All witnesses were sworn and the following documents were admitted into evidence.

EXHIBITS

Department's Exhibits:

D-1 Pre-Admission Screening (PAS) form, dated November 1, 2017

Appellant's Exhibits:

None

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 following Findings of Fact are set forth.

FINDINGS OF FACT

1) On November 1, 2017, a Pre-Admission Screening (PAS) was completed to determine the Appellant's eligibility for continued Long-Term Care services. The PAS was completed by the [redacted] (LTC facility). (Exhibit D-1)

2) An applicant must demonstrate a minimum of five (5) medical deficits on the PAS to meet criteria for nursing facility level of care.

3) On November 2, 2017, the Respondent issued a notice to the Appellant advising that he was awarded one (1) deficit in the functional area of *Bathing*. The notice advised the Appellant that his application for long-term care was denied because documentation did not reflect that he had five (5) deficits at the level required. (Exhibit D-1)

4) The case record reflects that on November 5, 2017, the Appellant indicated that he could not walk, could not bend over, could not stand, had no balance, used a wheelchair to assist with transfer to the restroom, got dizzy and felt as if he was going to faint, used oxygen at night, and needed assistance putting on socks.

5) The Appellant had a history of chronic pain, headaches affecting his vision, and sharp pain in his neck, shoulders, and left arm. (Exhibit D-1)

6) During the in-person fair hearing, the Appellant did not ambulate and used a wheelchair.

7) No evidence was presented to indicate what functional abilities the Appellant possessed during completion of the PAS to determine that he should not be awarded deficits in the functional areas of *Walking, Transfer, Wheeling, Dressing, Vacating, and Grooming*.

8) The Appellant's record identification (ID) number for the November 1, 2017 PAS was #217142. The fifth page of the PAS (also handwritten-labeled by the Respondent as page number 7) was dated October 20, 2017 and reflected record ID #216090. (Exhibit D-1)

9) On the PAS, Section III reflected "none" for the Appellant's current mental illness/mental retardation diagnoses; however, Section II reflected multiple mental illness diagnoses. (Exhibit D-1)

10) Items #38 and #39 are repeated on the fifth page and the sixth pages of the PAS (also handwritten-labeled by the Respondent as page number 8). The physician recommendations, physician signatures, and applicant signatures are not consistent. (Exhibit D-1)

11) The PAS provided inconsistent information and was unreliable. (Exhibit D-1)

12) Upon Nurse [redacted] request, a LTC facility progress note was submitted to KEPRO during the PAS review, however the progress note was not submitted as evidence during the hearing. (Exhibit D-1)

APPLICABLE POLICY

Bureau for Medical Services (BMS) Provider Manual §514.6.3 provides in part:

To qualify medically for the nursing facility Medicaid benefit, an individual must need direct nursing care twenty-four (24) hours per day, seven (7) days per week. BMS has designed 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. These deficits will be determined based on the review by BMS/designee 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 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 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…

DISCUSSION

Pursuant to policy, applicants for the LTC Medicaid benefit must be approved as medically eligible to receive direct nursing care twenty-four (24) hours per day, seven (7) days per week. KEPRO is the Utilization Management Contractor (UMC) responsible for conducting medical necessity reviews of the PAS to confirm a person's medical eligibility for the LTC Medicaid benefit. Per policy, the Appellant must have five (5) functional deficits on the PAS to qualify medically for nursing facility services. On November 1, 2017, Nurse [redacted] RN with KEPRO, reviewed the Appellant's PAS and awarded the Appellant one (1) deficit in the functional area of *Bathing*. On November 2, 2017, a Notice of Denial for Long-Term Care was sent to the Appellant stating that he did not meet the eligibility criteria threshold of five (5) functional deficits required to qualify for nursing facility services. The Appellant contended that he should not have been denied eligibility for the LTC Medicaid benefit because he requires a nursing facility level of care.

The Respondent had to demonstrate by a preponderance of evidence that the UMC followed policy in determining the Appellant's medical eligibility for LTC Medicaid benefits. The PAS was completed by staff at the LTC facility. The Appellant's written hearing request and testimony during the fair hearing contended that he should have been awarded deficits in additional functioning areas due to issues with walking, transferring to use the restroom, grooming, and pain. Progress notes provided to KEPRO during the PAS review were not submitted as evidence during the hearing. Evidence presented did not address what functional abilities the Appellant possessed that ruled out the Appellant being awarded additional deficits in the functioning areas of *Grooming, Dressing, Walking, Transfer, Vacating* and *Wheeling*.

The discrepancy between record ID numbers, dates, physician signatures, inconsistent information, and conflicting physician recommendations demonstrated that the validity of the information contained in the PAS was questionable. On the fourth page of the PAS, item #37 identified the Appellant as stable, with good rehabilitative potential, and listed the Appellant's primary, secondary, tertiary, and other medical conditions requiring services. On the fifth page of the PAS, #37 reflected no diagnoses or other medical conditions. On the fourth and fifth pages of the PAS, item #38 reflected physician recommendations of "services and care to meet these needs and can be provided of the level of care indicated;" however, the needs and level of care were not specified. On the sixth page of the PAS, item #38 reflected that the Appellant may be able to return home or be discharged and recommended a thirty (30) day estimated length of stay at a nursing home. It is unclear whether the same physician made both recommendations or if different physicians made the conflicting recommendations. On the fifth page of the PAS, item #39 does not clarify the name of the physician or the date the PAS assessment was completed. The first initial of the physician's written signature appears to be "N" and a handwritten note indicated "the resident refused to sign." No address is provided for the physician. On November 1, 2017, the typed signature of the physician, [redacted], was applied to item #39 on the sixth page of the PAS. No handwritten signatures for the physician or the Appellant were recorded. PAS attachment notes indicated that the Appellant refused to sign the November 1, 2017 application. The only record of a refused applicant signature is documented on a page dated October 20, 2017, that reflected an applicant record number inconsistent with the Appellant's PAS record number.

Because the information contained in the PAS cannot be relied upon to determine the Appellant's functional deficits, the Respondent's action to deny the Appellant's application for Long-Term Care Medicaid due to medical ineligibility was incorrect.

CONCLUSIONS OF LAW

1) Policy requires that an applicant demonstrate five (5) functional deficits on the Pre-Admission Screening (PAS) to qualify medically for Long-Term Care (LTC) Medicaid.

2) The Respondent relied upon the November 1, 2017 Pre-Admission Screening (PAS) completed by [redacted] to determine the Appellant's medical eligibility for LTC Medicaid.

3) The November 1, 2017 PAS was unreliable.

4) The Respondent was incorrect in its decision to deny the Appellant medical eligibility for LTC Medicaid based on the November 1, 2017 PAS.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Department's decision to deny the Appellant's application for Long-Term Care (LTC) Medicaid based on medical eligibility determined by the November 1, 2017 Pre-Admission Screening (PAS). The matter is **REMANDED** to complete a new PAS and a new determination of the Appellant's medical eligibility for LTC Medicaid. The new determination of medical eligibility will be subject to appeal from the Appellant.

ENTERED this 10th day of January 2018.

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Tara B. Thompson
State Hearing Officer