State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
P. O. Box 2590
Fairmont, WV 26555

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

August 28, 2006

_____
_____
_____

Dear Ms. _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held July 11, 2006. Your hearing request was based on the Department of Health and Human Resources' action to deny your application for Medicaid, Long Term Care (nursing home).

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 not 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 application for participation in the Medicaid Long-Term (Nursing Home) Care Program based on medical eligibility.

Sincerely,

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

cc: Erika H. Young, Chairman, Board of Review
Emily Keefer, RN, BMS
Oretta Keeney, RN, WVMI

BOARD OF REVIEW

_____ _____,

Claimant,

v. **Action Number: 06-BOR-1473**

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 August 28, 2006 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 July 11, 2006 on a timely appeal filed March 9, 2006.

II. PROGRAM PURPOSE:

The Program entitled Medicaid Long Term Care (nursing facility services) is set up cooperatively between the Federal and State governments and administered by the West Virginia Department of Health & Human Resources.

Nursing Home Care 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 standards for the care provided to eligible recipients. In order to qualify for Nursing Home Care, an individual must meet both financial and medical eligibility criteria.

III. PARTICIPANTS:

_____, MPOA, Claimant's Daughter / Representative
_____, Claimant's Daughter
[redacted]
Emily Keefer, RN, BMS (Participated Telephonically)
Stacy Holstine, RN, 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(s) 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 Income Maintenance Manual Sections 17.1 and 17.11.
West Virginia Medicaid Manual Section 508.2

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 West Virginia DHHR Policy Manual, Chapter §508.2 (Medicaid, Long-Term Care)
D-2 Pre-Admission Screening (PAS) completed January 19, 2006
D-3 Notice from WVMI dated February 1, 2006

VII. FINDINGS OF FACT:

1) On or about February 1, 2006, the Claimant was notified (Exhibit D-3) that her January 19, 2006 request for participation in the Long-Term Care (Nursing Home) Program was denied. This notices states, in pertinent part:

> 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 For), reflected deficiencies that meet the severity criteria in 3 areas identified below – Bathing, Dressing and Administering Medications.

2) The Department cited Medicaid policy guidelines and presented testimony to explain how the policy was applied to the medical findings documented on the Claimant's PAS. According to the Department's representatives, the Claimant's physician completed the medical assessment (PAS) and his documentation was relied upon to identify the three (3) areas (Bathing, Dressing and Administering Medications) that qualify as a deficit.

3) Representatives appearing on behalf of the Claimant expressed concerns about the Claimant's mental health but did not contest the medical findings on the PAS. As a matter of record, the Claimant's representatives indicated that they now have a better understanding of the medical eligibility criteria and acknowledged that she (the Claimant) does not demonstrate five (5) deficits as required by policy.

4) West Virginia Income Maintenance Manual Chapter 17.11, B - ESTABLISHING MEDICAL NECESSITY, THE PAS-2000, states:

When the PAS-2000 is completed before payment for nursing facility services can be made, medical necessity must be established. The PAS-2000 is used for this purpose. The PAS-2000 is signed by a physician and is evaluated by a medical professional of the State's contracted level of care evaluator (WVMI). The PAS-2000 is valid for 60 days from the date the physician signs the form. The 60-day validity period applies, regardless of the reason for completion, i.e., new admission, transfer to a different facility.

5) WV Long Term Care Policy §508.2, (Medical Eligibility) states 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. 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 facility benefit. These deficits may be any of the following:

- Decubitus – Stage 3 or 4

- Unable to vacate a building – a person is physically unable at all times, requiring one-person assistance with walking (Item 25i) or mentally incapable of leaving the building due to total disorientation, with a diagnosis of dementia, alzheimers, or related condition (Items 25g and 33).

- The individual needs hands-on assistance with eating, bathing, grooming, dressing, transferring and walking.

- The individual is totally incontinent of bowel or bladder. Total incontinence is when the individual has no control of bowel or bladder functions at any time.

- The individual is totally disoriented to time and place or is comatose

- The individual cannot navigate a wheel chair in the home and must not be able to walk in the home without physical assistance.

- The individual has skilled nursing care needs in one or more of these areas: suctioning, tracheostomy, ventilator, parenteral fluids, sterile dressings or irrigations.

- The individual is not capable of administrating his/her own medications.

The assessment tool designated by the Bureau for Medical Services must be completed, 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 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.

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 PAS revealed that the Claimant has three (3) program qualifying deficits in areas of Bathing, Dressing and Administering Medications.

3) The medical findings on the PAS were uncontested, and as a result, there were no additional deficits awarded to the Claimant.

4) Whereas the Claimant exhibits deficits in only three (3) of the specific categories of nursing services, the Claimant's medical eligibility for participation in the Medicaid Long-Term (Nursing Home) Care Program can not be established.

IX. DECISION:

It is the decision of the State Hearing Officer to **uphold** the action of the Department in denying the Claimant's application 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 28th Day of August, 2006.

_____

Thomas E. Arnett
State Hearing Officer