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

Martha Yeager Walker
Secretary

May 24, 2007

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_____
_____

Dear Ms. _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held May 23, 2007. Your hearing request was based on the Department of Health and Human Resources' proposal to close your Long Term Care Nursing Home case.

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 the Long Term Care Program is based on current policy and regulations. Some of these regulations state in part:

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 for Medical Services 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. (Bureau for Medical Services Policy Manual Chapter 508.2 MEDICAL ELIGIBILITY).

The information submitted at your hearing revealed: You meet the medical eligibility for continued services.

It is the decision of the State Hearings Officer to reverse the proposal of the Department to close your case.

Sincerely,

Ray B. Woods, Jr., M.L.S.
State Hearing Officer
Member, State Board of Review

cc: State Board of Review
Nora McQuain, RN – Bureau fro Medical Services
Oretta Keeney, RN – West Virginia Medical Institute
_____, Power of Attorney

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

_____,

Claimant,

v. **Action Number: 07-BOR-1263**

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 May 24, 2007 for Ms. _____. 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 on May 23, 2007 on a timely appeal filed April 26, 2007.

It should be noted here that the Claimant's benefits have been continued pending a hearing decision. A pre-hearing conference was not held between the parties, and the Claimant did not have legal representation.

II. PROGRAM PURPOSE:

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

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

_____, Sister/Power of Attorney*
[redacted] Licensed Social Worker for [redacted]*
[redacted] RN – Director of Nursing for [redacted]
Nora McQuain, RN – Bureau for Medical Services (B.M.S.)*
Oretta Keeney, RN – West Virginia Medical Institute (WVMI)*

Presiding at the Hearing was, Ray B. Woods, Jr., M.L.S., State Hearing Officer and a member of the State Board of Review.*

* Participated by conference call

IV. QUESTIONS TO BE DECIDED:

The question(s) to be decided is: Does the Claimant meet the medical eligibility for continued services under the Long Term Care Medicaid program?

V. APPLICABLE POLICY:

Bureau for Medical Services Policy Manual Chapter 508.2 MEDICAL ELIGIBILITY:

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:
D-1 Bureau for Medical Services Policy Manual Chapter 508.2 MEDICAL ELIGIBILITY:
D-2 PAS assessed on 04/11/07
D-3 Denial Letter from WVMI dated 04/16/07

Claimants' Exhibits:
None

VII. FINDINGS OF FACT:

1. Bureau for Medical Services Policy Manual Chapter 508.2 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

- #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 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 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 administrating his/her own medications.

The assessment tool designated by the Bureau for Medical Services must be completed and 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 Medicaid recipient who converts from Medicare Part A coverage to Medicaid does not need a new assessment to receive the Medicaid benefit. Medicaid coverage can be reinstated as long as a Medicare denial letter has been issued.

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 one 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.

2) The issue in this particular matter involves the denial of continued services under the Long Term Care Medicaid Program. The assessment was completed by the Nursing Facility Staff on April 11, 2007, and forwarded to WVMI (Exhibit D-2).

3) WVMI determined that the Claimant only had three (3) of the five required deficits for Long Term Care Services. The deficits were in the areas of: Vacating the building; Bathing; and Administering medications.

4) The WVMI issued a Denial Letter on April 16, 2007 (Exhibit D-3).

5) At the hearing, the B.M.S. RN explained the policy (Exhibit D-1). There were no questions from the participants.

6) At the hearing, the WVMI RN reviewed the PAS. There were no questions from the participants.

7) The area of disagreement between the parties was the Claimant's abilities under Question #25: (e.) Continence of bladder; (i.) Walking; and (j.) Wheeling.

8) Testimony received from the Claimant and Nursing Facility Staff indicated bladder incontinence on a daily basis. The B.M.S. RN advocated one (1) deficit for incontinence of bladder. The Claimant will be awarded one (1) deficit for bladder incontinence.

9) Testimony from the Claimant and Nursing Facility Staff revealed that the Nursing Facility Staff are trying to assist the Claimant gain confidence in the use of her walker within the facility. This requires at least one person assistance (Level 3).

10) The Claimant will be awarded one (1) deficit for Walking (Level 3).

11) Testimony from the Claimant, Nursing Facility Staff, and Power of Attorney revealed the Claimant uses her wheelchair to transfer from her bed to a wheelchair to go to the bathroom.

12) The Claimant will be awarded one (1) deficit for Wheeling (Level 3).

13) The Claimant receives three (3) additional deficits in the areas of: Bladder incontinence; Walking; and Wheeling.

VIII. CONCLUSIONS OF LAW:

1. Bureau for Medical Services Policy Manual Chapter 508.2 MEDICAL ELIGIBILITY requires that: An individual must have a minimum of five (5) deficits identified on the PAS in order to qualify for the Medicaid nursing facility benefit.

2. Testimony from the Claimant, Nursing Facility Staff, and Power of Attorney revealed the Claimant is eligible for three additional deficits. The deficits are in the areas of Bladder incontinence; Walking; and Wheeling.

3. The Claimant continues to be medically eligible for continued services under the Long Term Care Medicaid Program.

IX. DECISION:

It is the decision of this State Hearing Officer to reverse the proposed action of the Department in this matter

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 24th Day of May, 2007.

_____

Ray B. Woods, Jr., M.L.S.
State Hearing Officer