STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

Docket No. 2009-16010 OB

[redacted],

Appellant

_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant was represented by [redacted]. [redacted] appeared as a witness on behalf of the Appellant. [redacted] for the Department of Community Health represented the Department.

ISSUE

Did the Department properly determine that the Appellant does not require a Nursing Facility Level of Care?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a [redacted] Medicaid beneficiary.

2. The Appellant has a legal guardian.

3. The Appellant has been residing at the [redacted].

4. The Appellant is diagnosed with Schizoaffective disorder, thus must have an annual resident review to determine if his mental health needs are being met in the nursing facility.

5. The result of the specialized annual review revealed he does not require specialized mental health treatment; however, he also was found not to meet the Michigan Medicaid level of care standards for nursing home residents.

6. The assessment tool used to determine whether the Appellant requires nursing home care indicates he is medically stable.

7. The Appellant is not participating in any skilled therapies.

8. The Appellant is independent in all activities of daily living. He is continent of bowel and bladder.

9. The Appellant has no skilled nursing therapies.

10. The Appellant is ambulatory.

11. The Appellant's needs could be met in a less restrictive setting.

12. The Appellant's legal guardian was notified he does not meet the level of care standards in a notice issued [redacted].

13. On [redacted], the Appellant's guardian requested a formal administrative hearing.

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Effective November 1, 2004, the Michigan Department of Community Health (MDCH) implemented revised functional/medical eligibility criteria for Medicaid nursing facility, MI Choice, and PACE services. Federal regulations require that Medicaid pay for services only for those beneficiaries who meet specified level of care criteria. Nursing facility residents must also meet Pre-Admission Screening/Annual Resident Review requirements. The Medicaid Provider Manual, Coverages and Limitations Chapter, Nursing Facilities Section, April 1, 2005, lists the policy for admission and continued eligibility process as well as outlines functional/medical criteria requirements for Medicaid-reimbursed nursing facility, MIChoice, and PACE services.

> Section 4.1 of the Medicaid Provider Manual Nursing Facilities Section references the use of an online Michigan Medicaid Nursing Facility Level of Care Determination tool (*Michigan Medicaid Nursing Facility Level of Care Determination, March 7, 2005, Pages 1 – 9* or [LOC]). The LOC must be completed for all Medicaid-reimbursed admissions to nursing facilities or enrollments in MI Choice or PACE on and after November 1, 2004. All Medicaid beneficiaries who reside in a nursing facility on

November 1, 2004, must undergo the evaluation process by their next annual MDS assessment date.

Nursing facilities, MIChoice, and PACE have multiple components for determining eligibility for services. The Medicaid Provider Manual Nursing Facilities Section and the *Nursing Facility Eligibility and Admission Process, November 1, 2004, Pages 1-7* explain the components that comprise the eligibility and admission process for nursing facility eligibility and admission. The LOC is the assessment tool to be utilized when determining eligibility for admission and continued Medicaid nursing facility coverage. There are five necessary components for determining eligibility for Medicaid nursing facility reimbursement.

- Verification of Medicaid Eligibility
- Correct/timely Pre-Admission Screening/Annual Resident Review (PASARR)
- Physician Order for Nursing Facility Services
- Appropriate Placement based on Medicaid Nursing Facility Level of Care Determination
- Freedom of Choice.

See MDCH Nursing Facility Eligibility and Admission Process, Page 1 of 7, 11/01/04.

The Level of Care Assessment Tool consists of seven-service entry Doors. (Exhibit 1, Attachment 1). The doors are: Activities of Daily Living, Cognition, Physician Involvement, Treatments and Conditions, Skilled Rehabilitative Therapies, Behavior, or Service Dependency. In order to be found eligible for Medicaid Nursing Facility placement the Appellant must meet the requirements of at least one Door.

Door 1
Activities of Daily Living (ADLs)

The LOC, page 3 of 9 provides that the Appellant must score at least six points to qualify under Door I.

Scoring Door 1: The applicant must score at least six points to qualify under Door 1.
(A) Bed Mobility, (B) Transfers, and (C) Toilet Use:
• Independent or Supervision = 1
• Limited Assistance = 3
• Extensive Assistance or Total Dependence = 4
• Activity Did Not Occur = 8

(D) Eating:
• Independent or Supervision = 1

- Limited Assistance = 2
- Extensive Assistance or Total Dependence = 3
- Activity Did Not Occur = 8

The uncontested testimony was that the Appellant is and was independent in bed mobility, transfers, toilet use and eating. He was scored a 4 for this Door and requires a 6 to enter through this Door. The Appellant did not dispute this testimony.

Door 2
Cognitive Performance

The LOC, pages 3 – 4, provides that to qualify under Door 2 an Appellant must:

Scoring Door 2: The applicant must score under one of the following three options to qualify under Door 2.

1. "Severely Impaired" in Decision Making.
2. "Yes" for Memory Problem, and Decision Making is "Moderately Impaired" or "Severely Impaired."
3. "Yes" for Memory Problem, and Making Self Understood is "Sometimes Understood" or "Rarely/Never Understood."

The Appellant was not determined to meet the qualifying criteria for Door 2. He did not assert the determination was incorrect at this stage.

Door 3
Physician Involvement

The LOC indicates that to qualify under Door 3, the Appellant must:

…[M]eet either of the following to qualify under

1. At least one Physician Visit exam AND at least four Physician Order changes in the last 14 days, OR
2. At least two Physician Visit exams AND at least two Physician Order changes in the last 14 days.

There was no dispute between the parties that the Appellant did not qualify for Medicaid reimbursement by meeting the criteria set forth at Door 3. The undisputed evidence of record does not indicate the Appellant had at least two physician visit exams and at least two physician order changes in the 14 days prior to the LOC assessment date, the number necessary in order to qualify through this Door.

Door 4
Treatments and Conditions

The LOC, page 5, indicates that in order to qualify under Door 4, the Appellant must receive, within 14 days of the assessment date, any of the following health treatments or demonstrated any of the following health conditions:

A. Stage 3-4 pressure sores
B. Intravenous or parenteral feedings
C. Intravenous medications
D. End-stage care
E. Daily tracheostomy care, daily respiratory care, daily suctioning
F. Pneumonia within the last 14 days
G. Daily oxygen therapy
H. Daily insulin with two order changes in last 14 days
I. Peritoneal or hemodialysis

There is no evidence in the record supporting a finding the Appellant had any of the qualifying conditions listed as criteria for qualification under Door 5. The Appellant did not assert he met any of the criteria set forth at this door.

Door 5
Skilled Rehabilitation Therapies

The LOC, page 6, provides that the Applicant must:

> …[H]ave required at least 45 minutes of active ST, OT or PT (scheduled or delivered) in the last 7 days and continues to require skilled rehabilitation therapies to qualify under Door 5.

There is no evidence the Appellant was engaged in active physical or other rehabilitative therapy within the 7 day look back period. There is no evidence in the record the Appellant had met the qualification criteria listed at Door 5. He did not dispute the determination that he had not qualified through this entry Door.

Door 6
Behavior

The LOC, page 6, provides a listing of behaviors recognized under Door 6: Wandering, Verbally Abusive, Physically Abusive, Socially Inappropriate/Disruptive, Resists Care.

The LOC, page 8, provides that the Appellant would qualify under Door 6 if the Appellant had a score under the following two options:

1. A "Yes" for either delusions or hallucinations within the last 7 days.

2. The applicant must have exhibited any one of the following behaviors for at least 4 of the last 7 days (including daily): Wandering, Verbally Abusive, Physically Abusive, Socially Inappropriate/Disruptive, or Resisted Care.

There was no dispute the Appellant does not meet the qualifying criteria to enter through this Door.

Door 7
Service Dependency

> The Appellant could qualify under Door 7 if there was evidence that [he/she] is currently being served in a nursing facility (and for at least one year) or by the MIChoice or PACE program, **and** required ongoing services to maintain his current functional status. (emphasis added)

In order to qualify through this Door, services the Appellant is dependent on must not be available in the community. Here, the Appellant's guardian asserts he is dependent on services provided at the nursing home to meet his needs. She testified his condition and happiness are much improved since residing at the nursing home. She provided uncontested testimony he is more functional, social and happier since taking up residence at the facility.

Despite the compelling and emotional testimony from the Appellant's legal guardian regarding his improvement and happiness since entering the facility, this ALJ cannot find this evidence material to the disposition that must be made. Improvement in condition does not satisfy the requirement for service dependency. While it is compelling to hear the uncontested testimony regarding the appellant's improved status, this ALJ is without equitable jurisdiction in the matter and cannot disregard the criteria set forth by the Department.

The Department provided credible, uncontested evidence the Appellant's needs can be met in a less restrictive setting and that he is not service dependent. Additionally, he is not receiving skilled nursing care at the facility. He is medically stable and not otherwise able to satisfy the criteria as discussed above. There is no evidence upon which a finding could be made that the Appellant had met the qualifying criteria for Door 7 at the time the LOC assessment was completed. He had not been dependant upon nursing facility care for at least 1 year, or by MIChoice or PACE.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department correctly determined that the Appellant did not meet the Medicaid Nursing Facility Level of Care on [redacted].

IT IS THEREFORE ORDERED that:

The Department's decision is UPHELD.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/2/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.