STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Docket No. 2010-14817 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 [redacted]. The Appellant represented himself.

[redacted], long term care policy analyst for the Department of Community Health, represented the Department. Witnesses from the nursing facility includes: [redacted], Director of Nursing, [redacted], MDS coordinator & R.N., [redacted], MDS coordinator & R.N. and [redacted], [redacted] social worker.

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] year-old Medicaid beneficiary.

2. The Appellant has been residing in a nursing facility since admission in [redacted].

3. The Appellant had a Nursing Home Level of Care screening upon admission, [redacted]. It was determined he was eligible for nursing home placement due to meeting eligibility criteria at Door 5.

4. Restorative nursing and discharge plans were made for the Appellant.

5. The Appellant had a significant change in condition since admission to the facility.

6. The Appellant had a subsequent level of care determination conducted [redacted]. This determination resulted in a finding of ineligibility for continued placement in a nursing facility.

7. The Appellant is independent in bed mobility, toilet use, transferring and eating.

8. The Appellant does not have a short term memory problem, his cognitive skills are intact and he is able to make himself understood.

9. The Appellant has had zero (0) physician visits and one (1) physician order within the last 14 days.

10. The Appellant is not participating in skilled therapies, nor have any been ordered to continue.

11. The Appellant has not displayed wandering, socially inappropriate behavior, experienced delusions, hallucinations, been resistant to care, physically abusive or verbally abusive within the look back period specified in policy.

12. The Appellant has not been program dependent for at least one (1) year.

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

14. The Appellant was notified he was no longer eligible for Medicaid covered nursing facility placement on or about [redacted]. The Appellant has no skilled nursing therapies.

15. The Appellant requested a formal, administrative hearing [redacted].

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, January 1, 2010, 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 – BENEFICIARY ELIGIBILITY AND ADMISSION PROCESS
4.1 NURSING FACILITY ELIGIBILITY

There are five components for determining eligibility for Medicaid nursing facility reimbursement.

- Verification of financial Medicaid eligibility
- PASARR Level I screening
- Physician-written order for nursing facility services
- A determination of medical/functional eligibility via the Michigan Medicaid Nursing Facility Level of Care Determination
- Computer-generated Freedom of Choice form. These components are defined below.

4.1.A. VERIFICATION OF FINANCIAL MEDICAID ELIGIBILITY

Medicaid reimbursement for nursing facility services for an individual requires a determination of Medicaid financial eligibility for that individual by the Michigan Department of Human Services (DHS). When a Medicaid financially-eligible beneficiary is admitted to a nursing facility, or when a resident becomes Medicaid financially eligible while in a facility, the nursing facility must submit the Facility Admission Notice (MSA-2565-C) to the local DHS office to establish/confirm the individual's eligibility for Medicaid benefits. The facility should also submit the MSA-2565-C for residents who are potentially financially eligible.

DHS will return a copy of the MSA-2565-C to the facility noting an individual's Medicaid financial eligibility status and patient-pay amount (do not wait for DHS to return a copy of the MSA-2565-C; the online Michigan Medicaid Nursing Facility Level of Care Determination must be conducted within the required timeframe for Medicaid or Medicaid-pending beneficiaries). A copy of the MSA-2565-C is available on the MDCH website and in the Forms Appendix of this manual.

In order for Medicaid to reimburse for nursing facility services from the date of admission of a Medicaid-eligible beneficiary, the Medicaid beneficiary must be in a Medicaid-certified bed, and the Michigan Medicaid Nursing Facility Level of Care Determination must be completed online within 14 calendar days of admission.

Federal regulations require annual recertification that residents meet Medicaid financial eligibility requirements. The annual recertification process is performed by the Michigan Department of Human Services.

4.1.B. CORRECT/TIMELY PREADMISSION SCREENING/ANNUAL RESIDENT REVIEW (PASARR)

The Level I Preadmission Screening/Annual Resident Review (PASARR) must be performed prior to admission as described in the PASARR Process Section of this chapter.

A Level I Preadmission Screen must be performed for all individuals admitted to a Medicaid-certified nursing facility regardless of payer source. The Level I screening form (Preadmission Screening [PAS]/Annual Resident Review [ARR] (Mental Illness/Mental Retardation/Related Conditions Identification); DCH-3877) is available on the MDCH website. (Refer to the Directory Appendix for website information.) The nursing facility is required to ensure that the PASARR Level I screening has been completed and passed (does not trigger a PASARR Level II) by the individual prior to admission.

Placement options for individuals who are determined through Level II Preadmission screening to have a mental illness or mental retardation or of having a related condition are determined through the federal PASARR screening process requirements.

MDCH performs retrospective reviews, randomly and when indicated, to determine that the nursing facility has complied with federal PASARR requirements. MDCH reviews retrospectively to determine that the Level I screening was performed, and that the Level II evaluation was performed when indicated.

MDCH is required to recover any payments made to nursing facilities for the period that a participant may have been admitted to a nursing facility when the PASARR screening Process was not completed.

4.1.C. PHYSICIAN ORDER FOR NURSING FACILITY SERVICES

A physician-written order for nursing facility admission is required. By renewing orders, the physician certifies the need for continuous nursing facility care. The order must be signed and dated by the physician. The physician's degree must appear with the signature. A stamped signature is not acceptable.

With the exception of beneficiaries 21 years of age or under residing in a psychiatric facility, a physician (MD or DO) must approve a beneficiary's need for long-term care mot more than 30 calendar days prior to the beneficiary's admission to a nursing facility.

For an individual who applies for Medicaid financial eligibility while a resident in a nursing facility, the physician must reaffirm the need for long-term care not more than 30 calendar days prior to the submission of the application for Medicaid financial eligibility.

4.1.D. APPROPRIATE PLACEMENT BASED ON MICHIGAN MEDICAID NURSING FACILITY LEVEL OF CARE DETERMINATION

4.1.D.1. MICHIGAN MEDICAID NURSING FACILITY LEVEL OF CARE DETERMINATION

Financially eligible Medicaid residents must meet medical/functional eligibility for Medicaid reimbursed nursing facility services. To verify medical/functional eligibility, the nursing facility (i.e., hospital long term care unit, county medical care facility, ventilator dependent unit, hospital swing bed) must complete the Michigan Medicaid Nursing Facility LOC Determination prior to the start of Medicaid reimbursable services. The nursing facility must submit the information from the Michigan Medicaid Nursing Facility LOC Determination into its web-based version within 14 calendar days of admission. The nursing facility may not bill Medicaid for services provided if the beneficiary does not meet the established criteria identified either through the web-based version of the Michigan Medicaid Nursing Facility LOC Determination or the Nursing Facility LOC Exception Process, and may not bill the beneficiary unless the beneficiary has been advised of the denial and elects, in advance, to pay privately for services.

Services will only be reimbursed when the beneficiary is determined medically/functionally eligible through the web-based version of the Michigan Medicaid Nursing Facility LOC Determination and the Michigan Medicaid Nursing Facility LOC Determination was completed online within policy guidelines, or when the beneficiary is determined eligible through the Nursing Facility LOC Exception Process criteria. A copy of the Michigan Medicaid Nursing Facility LOC Determination, Field Definition Guidelines, Nursing Facility LOC Exception Process criteria and other information referenced in this section are available on the MDCH website. (Refer to the Directory Appendix for website information.) The website also contains contact information for technical support to:

- register to access the web-based assessment.
- complete the web-based assessment.
- complete the exception process.
- complete the immediate review process.
- transition beneficiaries.

The Michigan Medicaid Nursing Facility LOC Determination must be applied by a health professional (physician, registered nurse, licensed practical nurse, licensed clinical social worker [BSW or MSW], or licensed physician's assistant) representing the proposed provider. Non-clinical staff may perform the evaluation with clinical oversight by a licensed professional. The nursing facility must bill Medicaid only for beneficiaries who meet the web-based Michigan Medicaid Nursing Facility LOC Determination criteria or the Nursing Facility LOC Exception Process criteria.

The **web-based** Michigan Medicaid Nursing Facility LOC Determination must be completed as follows:

- Within 14 calendar days from the date of a new admission of a Medicaid-eligible applicant, regardless of primary payer source, where reimbursement is requested beyond Medicare co-insurance and deductible amounts.
- Within 14 calendar days from the date of a non-emergency transfer of a Medicaid-eligible resident to another nursing facility, including transfers originating from a nursing facility that is undergoing a voluntary facility closure. *Version Nursing Facility Date: January 1, 2010 Coverages Page 8*
- Within 14 calendar days from the date of disenrollment of a beneficiary from a Medicaid Health Plan which has been paying for nursing facility services.
- Within 14 calendar days from the date a Medicaid financial application was registered with the Department of Human Services by a current private-pay nursing facility resident
- requesting Medicaid as the payer for nursing facility services.
- Within 14 calendar days from the date a dually eligible beneficiary chooses to return to their Medicaid nursing facility bed, refusing their Medicare SNF benefit following a
- qualified Medicare hospital stay.
- Within 14 calendar days from the date of a Medicaid-eligible resident's transfer into a new nursing facility from a nursing facility that is undergoing an involuntary facility closure due to federal or state regulatory enforcement action. Nursing facilities do not need to complete the entire Michigan Medicaid Nursing Facility LOC Determination criteria, but must submit the information requested on the web-based Emergency/Involuntary Transfer form by selecting "Emergency/Involuntary Transfer" from the bottom of the LOC Determination welcome screen. Once admitted into the facility, however, the resident must meet the medical/functional eligibility criteria on an ongoing basis, as with all other residents covered under Medicaid fee-for-service as the primary payer. A proactive discharge plan must be provided to beneficiaries who fail to qualify, and an adverse action

notice must be issued if appropriate. Retrospective review of transferred residents will still apply.

- Within 14 calendar days from the date of a Medicaid-eligible resident's emergency transfer into a new nursing facility from a nursing facility experiencing a hazardous condition (e.g., fire, flood, loss of heat) that could cause harm to residents when such transfers have been approved by the State Survey Agency. Nursing facilities do not need to complete the entire Michigan Medicaid Nursing Facility LOC Determination criteria, but must submit the information requested on the web-based Emergency/Involuntary Transfer form by selecting "Emergency/Involuntary Transfer" from the bottom of the LOC Determination welcome screen. Once admitted into the new facility, however, the resident must meet the medical/functional eligibility criteria on an ongoing basis, as with all other residents covered under Medicaid fee-for-service as the primary payer. A proactive discharge plan must be provided to beneficiaries who fail to qualify, and an adverse action notice must be issued if appropriate. Retrospective review of transferred residents will still apply. Completion of the Michigan Medicaid Nursing Facility LOC Determination is not required for:
    - Hospice beneficiaries who are being admitted to the nursing facility for any services.
    - Nursing facility readmissions where a web-based Michigan Medicaid Nursing Facility LOC Determination was previously completed for the original admission and the beneficiary met the nursing facility criteria, and the beneficiary's level of care code determined by DHS has not changed.

The Michigan Medicaid Nursing Facility LOC Determination's medical/functional criteria include seven domains of need:

- Activities of Daily Living
- Cognitive Performance
- Physician Involvement
- Treatments and Conditions
- Skilled Rehabilitation Therapies
- Behavior
- Service Dependency For beneficiaries who qualify under Physician Involvement, Treatments and

> Conditions, or Skilled Rehabilitation Therapies, specific restorative nursing plans and assertive discharge planning must be evident and documented within the medical record (except for end-of-life care). These requirements are specified in the Process Guidelines.

The admitting provider must complete the web-based Michigan Medicaid Nursing Facility LOC Determination only one time for each Medicaid or Medicaid-pending beneficiary. However, if the beneficiary has a significant change in condition as noted in the provider's nursing notes or Minimum Data Set and that significant change in condition may affect the beneficiary's current medical/functional eligibility status, the provider must conduct a subsequent web-based Michigan Medicaid Nursing Facility LOC Determination.

If the resident is discharged and admitted to another provider, the new provider must complete the web-based Michigan Medicaid Nursing Facility Level of Care Determination within 14 days of admission, even if the new provider is owned by the same corporation as the previous provider. The Michigan Medicaid Nursing Facility Level of Care Determination is not conducted on a routine quarterly or annual basis.

4.1.D.2. NURSING FACILITY LEVEL OF CARE EXCEPTION PROCESS

The Nursing Facility Level of Care (LOC) Exception Review is available for Medicaidfinancially pending or Medicaid financially eligible beneficiaries who do not meet medical/functional eligibility based on the web-based Michigan Medicaid Nursing Facility LOC Determination criteria, but demonstrate a significant level of long term care need. The Nursing Facility LOC Exception Review process is not available to private pay individuals. The Nursing Facility LOC Exception Review is initiated only when the provider telephones the MDCH designee on the date the online Michigan Medicaid Nursing Facility LOC Determination was conducted and requests the Nursing Facility LOC Exception Review on behalf of a medically/functionally ineligible beneficiary. The Nursing Facility LOC Exception Criteria is available on the MDCH website. A beneficiary needs to trigger only one of the LOC Exception criteria to be considered as eligible under the Exception Review. Version Nursing Facility Date: January 1, 2010 Coverages Page 10 Michigan

> 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.

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. The Appellant did not dispute this testimony. He does not meet the eligibility requirements of this section.

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

The evidence of record establishes the Appellant did not have any of the listed conditions. He did state he is wheelchair dependent. The Department witness stated ambulation is not scored and is not considered relevant to determining whether a person requires nursing home placement. 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.

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. There is no evidence the Appellant's needs could not be met in the community or that he is service dependent for at least one year. There is no basis upon which this ALJ could find in his favor. 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.

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: 3/16/2010

***** 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.