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

IN THE MATTER OF:

[redacted] Docket No. 2012-21518 NHE

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] son represented the Appellant. He had no witnesses. [redacted], LTC Program Policy Analyst, represented the Department. Her witnesses from [redacted] were; [redacted] RN, [redacted], RN, and [redacted] LPN from [redacted]

PRELIMINARY MATTER:

The ALJ left the record open at the close of proofs to allow the Department time to investigate the Medicaid status of the resident of concern as a late question arose about that status and could not be verified at hearing. On [redacted] the Department representative determined that the Appellant/resident was a financially eligible Medicaid beneficiary and that the Department was not rescinding its action on LOCD and the record was closed.

ISSUE

Did the Department properly determine that the Appellant does not require a Medicaid reimbursable Nursing Facility Level of Care via the LOCD tool?

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. (Appellant's Exhibit #1)

2. On the date of LOCD [redacted] the Appellant was a resident of the [redacted]

3. The Appellant was admitted to the NF with a history of arthritis, dementia, blacking out due to low Hgb, HTN, and DJD. She receives no treatments. (Department's Exhibit A, page 8)

4. She was assessed under the NF LOCD on [redacted] under the NF LOC evaluation tool and was found to be independent at all domains, Doors 1 – 7. (Department's Exhibit A - throughout)

5. Following MPRO Immediate Review (IR) the Department determined, based on the LOCD evaluation, that the Appellant no longer met eligibility criteria for Medicaid reimbursed in-residence services at the NF. (Department's Exhibit A, pages 1, 7 and 8)

6. The Appellant was advised of the Department's action on [redacted] Her further appeal rights were contained therein. (Department's Exhibit A, pages 1 and 10)

7. The instant appeal was received by the Michigan Administrative Hearings System (MAHS) on [redacted] On the date of hearing the Appellant lives at home. (Appellant's Exhibit #1 and See Testimony of [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.

The Michigan Department of Community Health (MDCH) implemented functional/ medical eligibility criteria for Medicaid nursing facilities. Federal regulations require that Medicaid pay for services only for those beneficiaries who meet specified level of care criteria.

There are five necessary 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 based upon a web-based version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) that was conducted online at the time the resident was either Medicaid eligible or Medicaid pending and conducted within the timeframes specified in the Michigan Medicaid Nursing Facility Level of Care Determination subsection of this chapter.
- Computer-generated Freedom of Choice (FOC) form signed and dated by the beneficiary or the beneficiary's representative. [1]

Medicaid Provider Manual (MPM) §5 *et seq*
Nursing Facility Eligibility and [ ], pp. 7 - 14, April 1, 2012.

The MPM, [Nursing Facility Eligibility and Admission Section] lists the policy for admission and continued eligibility processes for Medicaid-reimbursed nursing facilities. This process includes a subsequent or additional web-based LOCD upon determination of a significant change in the beneficiary's condition as noted in provider notes or minimum data sets and that these changes may affect the beneficiary's current medical/functional eligibility status. *See* MPM 5.1.D

Section 5.1.D.1 further references the use of an online Level of Care Determination (LOCD) tool.

The LOCD is required for all Medicaid-reimbursed admissions to nursing facilities. A subsequent LOCD must be completed when there has been a significant change in condition that may affect the NF resident's current medical/functional eligibility status.

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

- Activities of Daily Living,
- Cognition,
- Physician Involvement,
- Treatments and Conditions,
- Skilled Rehabilitative Therapies, Behavior, and
- Service Dependency.

[1] This edition of the Medicaid Provider Manual is identical to the version in place at the time of LOCD assessment and appeal.

Individual residents or their authorized representatives are allowed to appeal *either* a determination of financial ineligibility to the Department of Human Services *or* medical/functional eligibility to the Department of Community Health:

> **APPEALS – Medical/Functional Eligibility**
>
> A determination by the web-based Michigan Medicaid Nursing Facility LOC Determination that a Medicaid financially pending or Medicaid financially eligible beneficiary is not medically/functionally eligible for nursing facility services is an adverse action. If the Medicaid financially pending or Medicaid financially eligible beneficiary or their representative disagrees with the determination, he has the right to request an administrative hearing before an administrative law judge. … MPM, §5.2.A, NF Eligibility, page 14, April 1, 2012

The Department presented testimony and documentary evidence that the Appellant did not meet any of the criteria for Doors 1 through 7.

Door 1
Activities of Daily Living (ADLs)

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 NF witness reviewers determined that the Appellant was independent in all fields of mobility.

Door 2
Cognitive Performance

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 NF witness reviewers determined that the Appellant scored 12 out of 15 points for a ranking of modified independent. They agreed on questioning from the Appellant's representative that the resident was usually understood.

Door 3
Physican Involvement

Scoring Door 3: The applicant must meet either of the following to qualify under Door 3:

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

The evidence presented is uncontested that the Appellant was not qualified under Door 3 as she did not have the minimum qualifying number of physician exam visits or physician order changes within 14 days of the assessment. She had one doctor visit and zero orders.

Door 4
Treatments and Conditions

Scoring Door 4: The applicant must score "yes" in at least one of the nine categories above and have a continuing need to qualify under Door 4.

In order to qualify under Door 4 the applicant 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

No evidence was presented indicating the Appellant had met the criteria listed for Door 4 at the time of the assessment.

Door 5
Skilled Rehabilitation Therapies

Scoring Door 5: The Appellant must have 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.

No evidence was presented indicating the Appellant had met the criteria listed for Door 5 at the time of the assessment.

Door 6
Behavior

Scoring Door 6: The applicant must score under one of the following 2 options to qualify under Door 6.

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.

No evidence was presented indicating that Appellant met the criteria set forth above to qualify under Door 6. The witnesses testified that the nursing notes certified that there were no behavioral issues during the 7-day look-back period.

Door 7
Service Dependency

Scoring Door 7: The applicant must be a current participant and demonstrate service dependency under Door 7.

The resident's date of admission to the NF was never provided – based on the MPRO review it is believed to be October 12, 2011. Thus, the evidence preponderates that the resident was not a NF resident/participant for one year.

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In this case, the Department representative, Aasted, questioned the NF witness Debra Hildabrand, RN/MDS coordinator concerning her preparation of the LOCD assessment conducted on [redacted].

That testimony showed that the Appellant, on [redacted], did not meet the qualifying criteria at any domain.

The Department witnesses added that on IR from MPRO their evaluation at the NF was verified. The MPRO review was conducted on [redacted].

The Appellant's representative focused his testimony on his mother's present condition as of the date of hearing stating that she now uses a wheelchair and has to propel the wheelchair with her feet in their home – which is difficult because the home is not wheelchair accommodating. He added that his mother has frequent bowel/bladder accidents – does not know she is dong it wrong and refuses help.

He concluded his testimony stating that his mother "while at the NF was private pay – not Medicaid."

The LOCD process is designed to be a snapshot of an individual's condition versus that person's need for NF services and Medicaid reimbursement thereto. When the LOCD merits no access through any domain of eligibility other processes and services attach subject to medical necessity.

The resident's physical and mental status may well have deteriorated since [redacted], however the LOCD conducted on [redacted] – and verified by MPRO IR on [redacted] - demonstrated independence under all domains of LOCD.

Based on the questioning posed by [redacted], the answers of the NF witnesses and their testimony the Department adequately demonstrated that the Appellant did not meet LOCD eligibility on review conducted [redacted].

The ALJ finds that the Appellant failed to preponderate her burden of proof to establish that the Department erred in reviewing her medical/functional eligibility status. The Appellant does not require Medicaid reimbursed NF level of care as demonstrated by the application of the LOCD tool.

If the Appellant was actually seeking to appeal his mother's financial determination – that action would be properly before the Department of Human Services – not DCH. appeal

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 does not require a Medicaid Nursing Facility Level of Care.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 4-20-12

***** 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.