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:

Docket No. 2012-28108 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 . The Appellant was present and testified. , the Appellant's daughter, represented the Appellant. , Director of , represented the Department of Community Health (Department). , 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 an -year old Medicaid beneficiary and resident of .
2. Prior to his , admission the Appellant was residing in . The Appellant was residing in his own home, suffered a stroke, was hospitalized, was discharged to a nursing home located in and then transferred to .
3. On , , assessed the Appellant eligibility for Medicaid covered Nursing Facility services using a Medicaid Nursing Facility Level of Care (LOCD) tool. determined that the Appellant did not meet criteria in any of the seven eligibility doors. (Department's Exhibit D.

4. On [redacted] on behalf of the Department, [redacted] sent the Appellant an Advance Action Notice in which it informed the Appellant that he was no longer eligible for Medicaid covered Nursing Facility services and that Medicaid funding would end [redacted] Department p 14 Exhibit E.

5. The Appellant did not request a review of the [redacted], [redacted].

6. [redacted], the Michigan Administrative Hearing System received the Appellant's request for an 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, MI Choice, 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, MI Choice, 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 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.

Medicaid Provider Manual,
Nursing Facility Coverages,
Section 5.1D. , p. 6, online p p.973
1/1/12.

The Level of Care Assessment Tool consists of seven-service entry Doors or domains. The doors are: Activities of Daily Living, Cognition, Physician Involvement, Treatments and Conditions, Skilled Rehabilitative Therapies, Behavior, or Service Dependency. The Medicaid Provider Manual policy provides the following :

> 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.

Medicaid Provider Manual,
Nursing Facility Coverages,
Section 5.1D. , p. 10, online p p.977
1/1/12.

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In order to be found eligible for Medicaid Nursing Facility placement the Appellant must meet the requirements of at least one domain or door. The evidence presented shows the following with regard to the Appellant's legibility for each door or domain.

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

Social Worker testified that she completed the Appellant . testified that she determined based on her observations and nursing home documentation that the Appellant was independent in Bed Mobility, Transfers, Toilet Use, and Eating. Neither the Appellant nor his daughter disputed conclusion regarding the Appellant's legibility under Door 1.

I find that correctly determined that the Appellant did not meet door 1 criteria Therefore the Appellant is not eligible for Medicaid covered services through Door 1.

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.”

testified that she tested that Appellant’s memory and concluded that the Appellant’s memory was okay, that he was independent in his cognitive skill for daily decision-making and was able to make himself understood. testified that she followed the Field Guide when evaluating the Appellant. testified that she does not agree with finding regarding the Appellant’s memory. testified that the Appellant is very forgetful and constantly has to be reminded regarding day to day fact and occurrences. testified that in her opinion the Appellant has a memory problem. also testified that the Appellant’s decision-making skills are impaired and he is not able to take care of himself since his stroke. The Appellant testified that he is not able to remember things, and cannot live by himself outside a nursing home.

In response to the testimony restated her opinion that the Appellant was given a memory test and passed. also testified that the Appellant was able to make independent daily decisions for the 7-day period before . el tested that she had no evidence that the Appellant was not able to make him understood.

I find that correctly determined that the Appellant did not meet door 1 criteria during the 7-day look back period. Therefore the Appellant is not eligible for Medicaid covered services through Door 1.

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.

estified that she reviewed the Appellant's medical records and found that the Appellant had no physician's visits and one order change during the 14 day look back period. Based on this information concluded that the Appellant did not meet door 3 criteria.

Neither the Appellant nor his daughter contested finding regarding Door 3. I find that correctly determined that the Appellant did not meet Door 3 criteria during the 14 day look back period. Therefore the Appellant is not eligible for Medicaid covered services through Door 3.

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 one of the following health treatments or demonstrated any one 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

testified that she reviewed the Appellant's records and found that during the 14 day look back period the Appellant did not demonstrate any of the health conditions listed nor did the Appellant receive any of the listed of treatments.

Neither the Appellant nor disputed finding for Door 4. I find that correctly determined that the Appellant did not meet Door 4 criteria during the 14 day look back period. Therefore the Appellant is not eligible for Medicaid covered services through Door 4.

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

testified that she reviewed the Appellant's medical records and found that the Appellant did not require or receive any Speech, Occupational or Physical Therapy during the 7 day look back period. testified that these therapies were for rehabilitation only and if the Appellant was approved for and receiving any of the listed was required to prepare a discharge plan for the Appellant.

testified that she thought the Appellant was involved in therapy because he was attending some type of therapy in the nursing home. l testified that the Appellant was voluntarily attending a program but did not have any physcian ordered therapy program.

I find that correctly determined that the Appellant did not meet Door 5 criteria during the 7 day look back period. Therefore the Appellant is not eligible for Medicaid covered services through Door 5.

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 one 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.

testified that she reviewed the Appellant's medical records a for the 7 day look back periods and found no documentation that the Appellant exhibited any of the following behaviors: wandering, verbally abuse, physically abusive, socially in appropriate or disruptive, or resistance to care. also testified that she found no evidence of delusions or hallucinations. testified that the Appellant behavior did not meet criteria under door 6 during the 7 day look back period.

Neither the Appellant nor disputed findings regarding Door 6.

I find that correctly determined that the Appellant did not meet Door 6 criteria during the 7 day look back period. Therefore the Appellant is not eligible for Medicaid covered services through Door 6.

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 MI Choice or PACE program, and required ongoing services to maintain her current functional status.

testified that the Appellant was admitted to on , and has resided at since his admission. l testified that the Appellant has not been in a nursing facility for at least one year and there are other community residential or informal services available to meet the Appellant's needs. testified that the Appellant did not meet Door 7 criteria.

testified that the Appellant was residing in his home located in in when he had a stroke. testified that he the Appellant was discharged from his home to a nursing facility. testified that the Appellant could not return to his home after his stroke so he was transferred to the . testified that at the time of the assessment the Appellant had not resided in a nursing home for but the r requirement should be waived because the Appellant can't return to his home and can't live alone in the community.

The Appellant testified that he can't live on his own and needs to be in a nursing home.

I find that correctly determined that the Appellant did not meet Door 7 criteria because at the time of the assessment the Appellant had not resided in a nursing home for one year. Therefore the Appellant is not eligible for Medicaid covered services through Door 7.

I find that the evidence presented shows that the Appellant did not meet legibility criteria for any of the seven doors or domains. The Department correctly determined through the assessment completed by that the Appellant is not eligible for Medicaid funded Nursing Facility services. The Appellant remains Medicaid eligible and may access all medically necessary Medicaid covered services available to him outside a nursing facility.

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 is not eligible for a Medicaid Nursing Facility Level of Care.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

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Martin D. Snider
Administrative Law Judge
For Olga Dazzo, Director
Michigan Department of Community Health

cc:

Date Mailed: ______3-20-12__________________

***** 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.