

**STATE OF MICHIGAN  
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES  
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

P.O. Box 30763, Lansing, MI 48909  
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**IN THE MATTER OF:**

**Docket No. 2013-37595 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 ██████████. ██████████ represented the Appellant. Her witness was ██████████. ██████████ LTC/MDCH manager represented the Department. Her witnesses were ██████████, R.N., MPRO, and ██████████ R.N., ██████████ NF.

**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 ██████-year-old Medicaid beneficiary. ( Appellant's Exhibit #1)
2. The Appellant is afflicted with "pain, medication issues, weight loss, and falls." (Appellant's Exhibit #1- throughout)
3. On the date of LOCD ██████████] the Appellant was a resident of the ██████████ nursing facility (NF). (Department's Exhibit A – hearing summary Sub. B)
4. She was assessed under the NF LOCD tool on ██████████ at 1:41 PM and was found to be independent in all domains; Doors 1 – 7. (Department's Exhibit A – hearing summary and sub B)
5. Following MPRO Immediate Review (IR) the Department determined based on the LOCD evaluation, that the Appellant no longer met eligibility criteria for

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Medicaid reimbursed, in-residence services at [REDACTED] NF.  
(Department's Exhibit A – C and See Testimony of [REDACTED])

6. On [REDACTED] the Appellant was advised, in writing, of the Department's negative action. Her further appeal rights were contained therein. (Department's Exhibit A, Sub D)
7. The instant appeal was received by the Michigan Administrative Hearings System (MAHS) on [REDACTED]. (Appellant's Exhibit 1 and Department's Exhibit A, Sub E)

**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.

Medicaid Provider Manual (MPM) §5 *et seq*  
Nursing Facility Eligibility and [REDACTED], pp. 7 - 14, January 1, 2013.

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 *generally*, 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.

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, January 1, 2013.

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 reviewer determined that the Appellant scored OK for short-term memory indicating independence and evidencing that she was usually able to make her self understood. The Appellant's representative/friend argued that she and family members have observed the Appellant to be repetitive in her questioning and in need of reminders to take her medications.

**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. She had 2 physician visits in the look-back period and zero physician orders. The Appellant's representative/friend argued that falls are not being reported by the Appellant or by staff thus no physician visits.

#### **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. The Appellant's representative/friend argued that the Appellant had pneumonia on admission to the NF.

#### **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 required any therapy]

**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 there were no behavioral issues during the 7-day look-back period. The Appellant’s representative/friend said that the Appellant is resistant to care and does not always want to take her medication.

**Door 7**  
**Service Dependency**

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

At the time of assessment, given an admission date of ██████████, the Appellant was not a program participant for over 1 year.

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

That testimony showed that the Appellant, on ██████████, did not meet qualifying criteria under any domain or door of eligibility.

The Department/MPRO witness ██████████, RN] added that on her review the evaluation by the NF was confirmed. The MPRO review was conducted the day after the LOCD review on ██████████.

The Appellant’s representative ██████████ focused her testimony on the global aspect of the Appellant’s physical and mental outlook. She believes that the Appellant is confused and needs supervision to take her medication – “...or she’ll end up in the hospital with pneumonia.” Her witness ██████████ echoed the observations of ██████████ stating that the Appellant is resistant to medication, eats very little and has

fallen many times without reporting the event. The witness said that the Appellant believes if she can "...still get up – [she hasn't] broken a bone."

On review, the Appellant's physical and mental status might or might not have deteriorated since her admission to the NF. However, the LOCD conducted on [REDACTED] – and as verified on immediate review conducted on [REDACTED] - demonstrated independence in all domains of LOCD captured during the mandatory look-back periods.

At hearing the Appellant's representative and her witness testified about events, personal and family observations not captured during the look-back periods as required under the assessment guidelines published in the Medicaid Provider Manual, [above].

Importantly for the Appellant and her family, as posited by Department's representative, [REDACTED], the NF is obligated to reassess any resident on observation of a significant change in condition.

Based on the questioning posed by [REDACTED], the answers of her witnesses and their credible testimony the Department adequately demonstrated that the Appellant did not meet LOCD eligibility on [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 through application of the LOCD tool.

**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.

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Dale Malewska  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

[REDACTED]

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cc:



Date Signed: June 27, 2013

Date Mailed: June 27, 2013

**\*\*\* NOTICE \*\*\***

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.