

**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) 373-4147

IN THE MATTER OF:

Docket No. 2013-58457 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 ██████████ ██████████ Appellant's authorized representative appeared and testified on the Appellant's behalf. Appellant also testified on her own behalf. ██████████, LTC Program Policy Specialist represented the Department of Community Health. Her witnesses were ██████████ ██████████, R.N., Michigan Peer Review Organization (MPRO) ██████████ ██████████ Manager, and ██████████, R.N., MDS Coordinator for ██████████

ISSUE

Did the Department properly determine that the Appellant does not require a Medicaid reimbursable 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. Appellant is an ██████████-year-old Medicaid beneficiary (██████████) and current resident of ██████████ (██████████) in ██████████ (Exhibit A, Items B-D & G and testimony).
2. On ██████████, ██████████ conducted an assessment under the Nursing Facility (NF) Level of Care Determination (LOCD) and determined the Appellant eligible under Door 1 – Activities of Daily Living to receive Medicaid reimbursed services in a nursing facility. (Exhibit A, Item B and testimony).

3. On ██████████, Appellant was assessed again under the NF LOCD and ██████████ found her to be ineligible to receive Medicaid reimbursed services in a nursing facility. (Exhibit A, Item C and testimony).
4. On ██████████, was given an Advance Action Notice by ██████████ advising her that she no longer qualified for Medicaid covered nursing facility level services based on the recent NF LOCD. Appellant then contacted MPRO and requested a NF Exception Review (Immediate Review). (Exhibit A and Item D).
5. On ██████████, MPRO based their review on the Appellant's medical records provided by ██████████ and determined the Appellant was ineligible for Medicaid covered nursing facility level services. MPRO based their denial on the NF Exception Review criteria. MPRO issued Appellant an adverse action notice advising that her Medicaid covered nursing facility level services would be terminated in ██████ days. The notice advised the Appellant of her rights to a Medicaid Fair Hearing. (Exhibit A and Items D-F).
6. On ██████████ Appellant's Request for Hearing was received by the Michigan Administrative Hearing System (MAHS). (Exhibit A and Item G).

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, Nursing Facility Coverages, Section 5 - Beneficiary Eligibility and Admission Process, pp. 7 - 15, July 1, 2013.

The *Medicaid Provider Manual, Nursing Facility Coverages, Section 5 - Beneficiary Eligibility and Admission Process* 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. (Emphasis supplied) See Medicaid Provider Manual (MPM) Subsection 5.1.D

Subsection 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.2., NF Eligibility, page 14, July 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 Department's witness from Camelot determined that Appellant was independent for Bed Mobility, Transfers, and Eating, but required supervision for Toilet Use. As such, the Appellant only scored a 4 on Door 1, so she no-longer qualified through Door 1.

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 Department's witness from Camelot determined that Appellant's short-term memory was okay, that her cognitive skills for daily decision making were independent, and that she was able to make herself understood. As such, Appellant did not qualify under Door 2.

Door 3
Physician 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 Department's witness from Camelot determined the Appellant had no physician exam visits and only three physician order changes within 14 days of the assessment. As such, Appellant did not qualify under Door 3.

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

The Department's witness from Camelot determined the Appellant did not meet 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.

The Department's witness from Camelot determined the Appellant did not meet 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.

The Department's witness from Camelot determined the Appellant did not meet the criteria set forth above to qualify under Door 6.

Door 7
Service Dependency

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

The LOC Determination provides that the Appellant could qualify under Door 7 if she is currently (and has been a participant for at least one (1) year) being served by either the MI Choice Program, PACE program, or Medicaid reimbursed nursing facility, requires ongoing services to maintain current functional status, and no other community, residential, or informal services are available to meet the applicant's needs.

Here, Appellant had been a nursing facility resident for more than one year, but the Department witness from Camelot testified that Appellant no longer required a NF level of care to maintain her current functional status.

Exception Process

The Nurse Reviewer with MPRO testified and provided documentation that MPRO received the NF Exception Review request from the Appellant a resident at Camelot. (Exhibit A and Items D-F and testimony).

The Michigan Department of Community Health policy related to LOC exception eligibility for nursing facility services is found in its Medicaid Provider Manual:

5.1.D.2 Nursing Facility Level of Care Exception Process

The Nursing Facility Level of Care (LOC) Exception Review is available for Medicaid financially 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.

*Medicaid Provider Manual,
Nursing Facility Coverages,
July 1, 2013 Page 12.*

The exception process considers frailty, behaviors and treatments. The Nurse Reviewer stated she received the Appellant's call for an MPRO review on ██████████ and they proceeded to obtain the Appellant's medical records from ██████████ to do their review. The Nurse Reviewer went through each of the exception criteria in detail. The Appellant did not meet any of the exception criteria based on the information provided by the nursing facility. (Exhibit A, Items D-F and testimony). The Nurse Reviewer with MPRO concluded her testimony concerning the review by pointing out that the Appellant's medical records did not show the need for any complex treatments or nursing care. Since the Appellant did not meet the criteria for an exception, MPRO upheld the denial decision and sent Appellant an Adequate Action Notice on ██████████. (Exhibit A, Item F).

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Appellant's witnesses testified the Appellant had been at ██████████ for over ██████ years. Appellant's witnesses agreed the Appellant was doing real well at ██████████. They stated the Appellant has received excellent care while at ██████████. Appellant's witnesses stated they were afraid the Appellant's health would decline if she were to leave ██████████ that she might not be able to manage her health problems on her own. Appellant's witnesses also noted that the Appellant had been to her cardiologist for a routine follow-up on ██████████. Appellant read the cardiologist's report into the record to establish her history of medical conditions. The cardiologist's primary concern following the routine follow-up was her shortness of breath after minimal ambulation. The cardiologist recommended a chest x-ray and a basic metabolic profile to determine the cause of her current symptoms, and recommended a follow-up in ██████ months.

Appellant also indicated she had a bad hip and needs a hip replacement, but cannot have the replacement due to her medical condition. Appellant stated it would be very traumatic for her if she had to leave ██████████. Appellant was also concerned that her monthly ██████████ of ██████████ per month would not be enough to support her in some type of independent living arrangement if she left ██████████.

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 Department's representative pointed out that currently the Appellant is only receiving non-skilled care at ██████████ and does not require Medicaid covered nursing facility care. The Department's representative did acknowledge that the Appellant was eligible for Medicaid covered services, but that her current needs can be met through Medicaid covered services available in the community.

Based on the evidence presented the Department adequately demonstrated that the Appellant did not meet LOCD eligibility on the review conducted ██████████. The undersigned 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.

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.


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IT IS THEREFORE ORDERED that:

- The Department's decision is AFFIRMED.

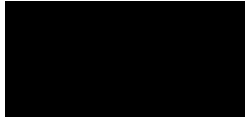
William D Bond

William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: 

Date Mailed: 

WDB/db

cc: 

***** 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.