

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. 2014-20762 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 ██████████ appeared on the Appellant's behalf. The Appellant, ██████████, Appellant's sister, and ██████████, Licensed Social Worker/Geriatric Manager with Senior Solution of Michigan all testified on the Appellant's behalf. Assistant Attorney General ██████████ represented the Department of Community Health. ██████████ LTC Program Policy Specialist with the Department of Community Health, and ██████████, RN, MDS Coordinator with ██████████, testified on behalf of the Department.

ISSUE

Did the Department properly determine that the Appellant did 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 a ██████-year-old Medicaid beneficiary (██████████) and current resident of ██████████ (██████████) (Exhibit A, Hearing Summary and testimony).
2. On ██████████ conducted an assessment under the Nursing Facility (NF) Level of Care Determination (LOCD) and found Appellant to be eligible to receive Medicaid reimbursed services in a nursing facility under Door 1. (Exhibit A, Attachment B and testimony).

3. On ██████████, RN, MDS Coordinator with ██████████, conducted another assessment under the Nursing Facility (NF) Level of Care Determination (LOCD) and found her to be ineligible to receive Medicaid reimbursed services in a nursing facility. (Exhibit A, Attachment C and testimony).
4. On ██████████, Appellant's Request for Hearing was received by the Michigan Administrative Hearing System (MAHS). (Exhibit A, Attachment D and testimony).

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, §5 Beneficiary Eligibility and Admission Process, pp. 7 - 15, October 1, 2013*].

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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 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:

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. . . . *Medicaid Provider Manual, §5.2.A.2., Nursing Facility Coverages, p. 14, October 1, 2013.*

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██████████, the Department's Long Term Care Program Policy Specialist, stated the LOCD is required to be done in order to continue services in a nursing facility when there has been a change in the resident's condition. If the subsequent LOCD shows the resident is ineligible, the resident will be discharged from the facility. ██████████ stated there is a look back period of 7 days for Doors 1, 2, 5, and 6. There is a 14 day look back period for Doors 3 & 4. ██████████ stated the nursing notes will be reviewed to complete the new LOCD. ██████████ also stated the resident must have been in the facility for over █ year or she must be in need of nursing facility level of care to remain eligible for Medicaid covered services in a nursing facility.

██████████ indicated the Appellant in this case could have asked MPRO for an immediate review of the LOCD determination in this case, or for an exception review utilizing the frailty criteria. There was no request for either type of review in this case. ██████████ stated she reviewed the letter prepared by ██████████ the social worker hired by the Appellant's sister in this case, and she stated the observations made by ██████████ in her letter related to dressing, grooming, and bathing which are not the ADLs that are assessed when doing a LOCD. (Exhibit A, Attachment E). She also noted the Appellant's eye infection that was mentioned is also not one of the medical conditions listed in the LOCD under Door 4. ██████████ stated you must follow the look back periods for the LOCD, and more recent observations or medical care or treatments are not relevant to the question of whether the ██████████ LOCD was completed properly.

The Department also presented testimony and documentary evidence that the Appellant did not meet any of the criteria for Doors 1 through 7. ██████████ with ██████████ completed a LOCD on ██████████ and determined the Appellant was not eligible for continued Medicaid covered care in their skilled nursing facility. Nurse Chimosky stated she was prompted to do an updated LOCD in response to a quarterly evaluation done by ██████████ Social Worker, which showed a significant improvement in the Appellant's condition. According to the quarterly assessment Appellant was now independent in bed mobility, transfers, and toilet use, and when she was admitted to the nursing facility in ██████████ she was rated extensive assistance for these ADLs.

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 ██████████ determined that the Appellant needed supervision for Bed Mobility, Toilet Use, Transfers and Eating. ██████████ used the nursing notes to make these determinations. ██████████ also said she was familiar with the Appellant and would see her almost every day at ██████████. Accordingly, Appellant did not qualify under 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 ██████████ determined that the Appellant's cognitive skills were modified independent. As such, Appellant did not qualify under Door 2.

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 Department's witness from ██████████ determined the Appellant had one physician visit and one physician order change 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 ██████████ determined the Appellant did not meet the criteria listed for Door 4 at the time of the assessment as she had none of the health treatments or conditions listed above.

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 ██████████ determined the Appellant did not meet the criteria listed for Door 5 at the time of the assessment. The Appellant was not receiving any skilled rehabilitation therapies within the past 7 days.

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 ██████████, ██████████ found the Appellant did not meet the criteria set forth above to qualify under Door 6. A review of her records showed that she did not exhibit any of the listed behaviors within 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 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 not been a nursing facility resident for at least one year. ██████████ testified the Appellant was admitted to ██████████ in ██████████ and her review was done on ██████████. Furthermore, according to the LOCD completed by ██████████ as of the ██████████ the Appellant no longer needed ongoing nursing facility services to maintain her current functional status, and other community, residential, or informal services that are available to the appellant would be sufficient to meet the Appellant's needs. Accordingly, Appellant did not qualify under Door 7.

Appellant's sister testified at the hearing that the Appellant has a rare form of muscular dystrophy, a degenerative muscular disease. Appellant's sister stated she believes the Appellant should be in a skilled nursing facility because she needs clinical assessments for her eyes and legs. Appellant's sister testified the Appellant gets help getting out of bed and pushes her wheel chair using her legs. She stated the Appellant has been in the nursing facility for almost a year and they did not state that her condition had gotten worse. Appellant's sister indicated she has had problems since ██████████ getting complete medical records from ██████████. She stated she had to call last Friday to get the notes from the ██████████ psychiatric evaluation. Appellant's sister stated in her opinion she believes the ██████████ LOCD is not correct.

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The Appellant testified that she thinks she is getting the care she needs at [REDACTED]. Appellant testified that she needs [REDACTED] hour care. She said she needs help getting out of bed and going to the bathroom, but does not need any help with her medications. Appellant testified she believes she would benefit from physical therapy and by seeing a therapist or a psychiatrist. Appellant said she is a little more independent than she was when she first came to the nursing facility. She said she can sit up now, but needs help getting into her wheelchair and to the toilet.

[REDACTED] testified she was a licensed social worker and geriatric care manager. [REDACTED] said she was called in as an outsider (hired) by the Appellant's sister. She stated she was retained on [REDACTED]. In her letter dated [REDACTED], she advised that she met with the Appellant the past week, around [REDACTED]. [REDACTED] stated she met with the Appellant and White Pine's social worker. [REDACTED]. She stated they discussed the Appellant's ADLs.

[REDACTED] said she determined that the Appellant needed limited assistance with showering/bathing, grooming, and hygiene. She asked the Appellant if she was able to get out of her chair, but the Appellant refused because she was afraid she might fall. [REDACTED] stated she examined the Appellant's legs and she was not wearing her Ted Hose, because she needed help putting them on. [REDACTED] stated she suggested to [REDACTED] that the Appellant could benefit from physical therapy for strengthening and also from a psychiatric evaluation. [REDACTED] stated these suggestions were followed by the nursing facility. [REDACTED] stated it was her opinion that the Appellant could have benefitted from these services prior to that time.

[REDACTED] said she is familiar with the Appellant's degenerative disease and doesn't believe she can live independently. She believes the Appellant needs care [REDACTED] and needs help with most of her ADLs. [REDACTED] said she does not agree with the [REDACTED] LOCD. She believes that inadequate care by the nursing facility allowed for an inaccurate assessment.

In response to questions by the Department's attorney, [REDACTED] acknowledged that she is familiar with LOCDs. She is aware of the limited ADLs that are reviewed for an LOCD assessment. [REDACTED] acknowledged that her observations related in her [REDACTED] letter regarding the Appellant's need for assistance with such things as showering/bathing, or getting dressed are not a part of the LOCD assessment. She was aware that the eye infection mentioned was not one of the specific medical conditions listed for Door 4, and she did not know how many doctor visits or order changes the Appellant had during the 14 day look back period. [REDACTED] acknowledged that her observations of the Appellant were made sometime after the LOCD was done. She admitted she did not do a complete assessment of the ADLs listed on the LOCD. [REDACTED] said she believed the Appellant needed limited assistance with bed mobility and under Door 2 she would be rated modified independent.

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The LOCD process is designed to be a snapshot of an individual's condition versus that person's need for Medicaid covered NF services. When the LOCD shows the individual does not meet the eligibility criteria for nursing facility level of care, other Medicaid covered services should be considered for that individual. The Appellant may be financially eligible for Medicaid covered services, but her current needs may be met through Medicaid covered programs and services available in the community.

Based on the evidence presented the Department adequately demonstrated that the Appellant did not meet LOCD eligibility on [REDACTED]. The undersigned ALJ finds that the Appellant failed to meet her burden of proving that the Department erred in reviewing her medical/functional eligibility status. The Appellant's suggestion that the level of care given to the Appellant by the nursing facility affected the accuracy of the LOCD assessment is without merit. There was no evidence presented that there was any concern about the level of care being provided to the Appellant prior to the unfavorable LOCD. The preponderance of the evidence in this case shows that the Appellant did not require Medicaid reimbursed NF level of care as demonstrated by the LOCD completed on [REDACTED].

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 require a Medicaid Nursing Facility Level of Care as demonstrated by the application of the LOCD tool on [REDACTED].

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: [REDACTED]

Date Mailed: [REDACTED]

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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.