

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. 2014-32301 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 ██████████ ██████████ one of Appellant's guardians, appeared and testified on the Appellant's behalf. ██████████ ██████████, was also present but did not testify.

██████████ LTC Program Policy Specialist with the Department of Community Health, ██████████ RN, MDS Coordinator with ██████████ ██████████), and ██████████ R.N., PACER Project Manager with MPRO 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, Item B and testimony).
3. On ██████████ conducted another assessment under the Nursing Facility (NF) Level of Care Determination (LOCD) and found

Appellant ineligible to receive Medicaid reimbursed services in a nursing facility. (Exhibit A, Item C and testimony).

4. On ██████████ contacted the Michigan Peer Review Organization (MPRO) and requested a NFLOC immediate review. (Exhibit A, Items D & E, and testimony).
5. On ██████████, based upon the NFLOC Exception criteria, MPRO determined the Appellant did not meet the review and upheld ██████████ denial decision. (Exhibit A, Items D & E, and testimony).
6. 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, p. 7 January 1, 2014].

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, January 1, 2014.*

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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. ██████████ along with ██████████ at ██████████ established that 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. ██████████ also stated for Door 7 the resident must have been in the facility for over 1 year or he must be in need of nursing facility level of care to remain eligible for Medicaid covered services in a nursing facility.

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.

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 was independent for Bed Mobility, Toilet Use, Transfers and Eating. ██████████ used the nursing notes to make these determinations. 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 ██████████ consulted with the Appellant's social worker determined that the Appellant's had no short term memory problems, no problems with decision making, he could make himself understood, and cognitive skills were independent. The social worker conducted a MMSE (Mini Mental State Exam), and the Appellant scored ██████ out of ██████, indicating his mental state was pretty good. 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 ██████████ determined the Appellant had no physician visits 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 he 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 █ days, and did not have any scheduled.

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 his records showed that he 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 he 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 ██████ year. ██████ testified the Appellant was admitted to ██████ in ██████ and his 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 his current functional status. Accordingly, Appellant did not qualify under Door 7.

Exception Process

██████████, R.N., PACER Project Manager with MPRO testified and provided documentation that MPRO received the NF Exception Review request from the Appellant's daughter-in-law, one of the Appellant's guardians, on ██████ (Exhibit A Item D 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, January 1, 2014, p. 12*].

The exception process considers frailty, behaviors and treatments. ██████, R.N., PACER Project Manager with MPRO testified she received ██████ call for an MPRO review on ██████. They proceeded to obtain the

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Appellant's medical records for the past █████ months from █████ to do their review. █████ went through each of the exception criteria in detail. The Appellant did not meet any of the exception criteria based on the medical records provided by the nursing facility. (Exhibit A, Items D & E and testimony).

For the frailty categories, 1001, for toilet use, transfers, and bed mobility Appellant was independent. For 1002, there was no documented consistent shortness of breath, pain, or debilitating weakness. For 1003, there were no documented falls within the past month.

For 1004, there was no mention of medication set up as the facility was dispensing all medications. For 1005, meals were being provided by the facility, Appellant had a weight gain of 24 pounds due to eating a lot of candy, and edema was noted in his ankles. For 1006, there were no physician visits, no ER visits, and no order changes within the past 14 days.

For the Behavior categories, 2001-2004 there was no wandering, no verbal or physical abuse, and no socially inappropriate behaviors were mentioned in the Appellant's medical records. For 3000, █████ stated the Appellant's medical records did not show that he resisted care, or that there was a 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 █████ stated she contacted the Appellant's daughter-in-law and the facility, and a letter was sent to them to advise that the facility's decision was upheld. (Exhibit A, Item D & E).

Appellant's daughter-in-law testified at the hearing that the Appellant was doing well today because he is in the nursing facility. She said when he is out he does not do well. For example he was released from █████ on █████, and was admitted █████ weeks later to █████ on █████. Appellant's daughter-in-law stated that physically the Appellant is fine, but has some dementia. She said Appellant is a gambler and an alcoholic.

Appellant's daughter indicated the Appellant will be back in a nursing facility if he left unsupervised. She further indicated he has had █████ hospitalizations in the past █████ years, and has been in █████ different nursing facilities. However, when asked by █████ which Door she thought the Appellant would qualify under, Appellant's daughter-in-law said she did not know if he would qualify. She said that she had checked around and believes he falls in a gray area.

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 his current needs may be met through Medicaid covered programs and services available in the community.

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Based on the evidence presented the Department adequately demonstrated that the Appellant did not meet LOCD eligibility on [REDACTED]. The MPRO Immediate Review also upheld that determination. The undersigned ALJ finds that the Appellant failed to meet his burden of proving that the Department erred in reviewing his medical/functional eligibility status. 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]

WDB/db

cc: [REDACTED]

***** 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.