STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 15-003249 NHE

[redacted]

Appellant

[redacted]/

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 [redacted]. [redacted], Appellant's daughter and authorized hearing representative, appeared and testified on the Appellant's behalf.

[redacted], Manager of Appeals Section for the Department of Health and Human Services appeared on behalf of the Department. [redacted], LTC Program Policy Specialist with the Department of Health and Human Services; [redacted], Resident Care Coordinator, and [redacted], Resident Social Worker, with [redacted] Medical Care Facility; and, [redacted], R.N., PACER Project Manager with [redacted] 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 an [redacted]-year-old Medicaid beneficiary (DOB 1[redacted] and current resident of [redacted] Medical Care Facility [redacted]). (Exhibit A, Items B, C and testimony).

2. On [redacted] conducted an assessment of the Appellant under the Nursing Facility (NF) Level of Care Determination (LOCD) and found Appellant eligible to receive Medicaid reimbursed services

in a nursing facility under Door 5 – Skilled Therapy, the Appellant having received over [redacted] minutes of skilled therapies. (Exhibit A, Item B and testimony).

3. On [redacted] conducted another assessment of the Appellant under the Nursing Facility (NF) Level of Care Determination (LOCD) based on a significant change in condition and found the Appellant ineligible to receive Medicaid reimbursed services under any of the doors on the LOCD. (Exhibit A, Item C and testimony).

4. On [redacted], Resident Care Coordinator with [redacted] contacted MPRO and requested a NFLOC Exception review. (Exhibit A, Items D & E and testimony).

5. On [redacted], based upon the NFLOC Exception criteria, [redacted] determined the Appellant did not meet the review criteria. On [redacted] issued the Appellant an adverse notice. (Exhibit A, Items D-F and testimony).

6. On [redacted] conducted another assessment of the Appellant under the Nursing Facility (NF) Level of Care Determination (LOCD) and again found the Appellant ineligible to receive Medicaid reimbursed services under any of the doors on the LOCD. (Exhibit A, Item G and testimony).

7. On [redacted] the Appellant's daughter contacted [redacted] and requested an NFLOC Immediate review on behalf of the Appellant. (Exhibit A, Item H and testimony).

8. On [redacted], [redacted] determined the Appellant was ineligible. (Exhibit A, Item H).

9. On [redacted], [redacted] issued the Appellant an adverse notice. (Exhibit A, Item I and testimony).

10. On [redacted], Appellant's Request for Hearing was received by the Michigan Administrative Hearing System (MAHS). (Exhibit A, Item J 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 Health and Human Services (MDHHS) 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, 2015].

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, 2015.

[redacted] Resident Care Coordinator for [redacted] Medical Care Facility established that based on a review of the Appellant's electronic charts, the paper charts and the CNA's charts regarding the Appellant's ADLs kept by the [redacted] Medical Care Facility, the Appellant did not meet any of the criteria for Doors 1 through 7. [redacted]i completed LOCDs on [redacted] and again on [redacted] and determined the Appellant was not eligible for 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

[redacted], Resident Care Coordinator for [redacted] determined the Appellant was independent for Bed Mobility, Toilet use and Eating, and she needed supervision for Transfers. 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."

[redacted], Resident Care Coordinator for [redacted] determined the Appellant had no short term memory problems, she could make herself understood, and her cognitive her skills were 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.

[redacted], Resident Care Coordinator for [redacted] determined the Appellant had no physician visits and no 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

[redacted] Resident Care Coordinator for [redacted] 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. Thus, she did not qualify under Door 4.

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.

[redacted] Resident Care Coordinator for [redacted] determined the Appellant did not meet the criteria listed for Door 5 at the time of the assessment. The Appellant last received any skilled rehabilitation therapy on [redacted] Accordingly, the Appellant was not receiving any skilled rehabilitation therapies and did not have any scheduled within the 7 days prior to the LOCDs. Thus, she did not qualify under Door 5.

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.

[redacted] Resident Care Coordinator for [redacted] 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. Thus, she did not 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.

The Department's evidence establishes that the Appellant was first admitted to [redacted] on [redacted] and she was found to be ineligible for Medicaid reimbursed nursing facility level of care on [redacted] and again on [redacted] Accordingly, Appellant did not qualify under Door 7.

Exception Process

[redacted] R.N., PACER Project Manager with MPRO testified and provided documentation that on [redacted], Resident Care Coordinator with [redacted] contacted MPRO and requested a NFLOC Exception review. [redacted] indicated that based on her telephone interview with [redacted] and the NFLOC Exception criteria, [redacted] determined the Appellant did not meet the review criteria. [redacted] indicated that on [redacted] issued the Appellant an adverse notice.

[redacted] further indicated that [redacted] received an NF Immediate Review request from [redacted], the Appellant's daughter on [redacted]. Thereafter, on [redacted] 5 they received the Appellant's medical records from [redacted], Resident Care Coordinator with [redacted] Medical Care Facility. (Exhibit A, Item H 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, 2015, p. 12].

The exception process considers frailty, behaviors and treatments. [redacted] reviewed the medical records from [redacted], Resident Care Coordinator with [redacted] Medical Care Facility on [redacted]. [redacted] went through each of the exception criteria in detail and determined the Appellant did not meet any of the exception criteria based on the medical records provided by the nursing facility. (Exhibit A, Item H and testimony).

For the frailty categories, 1001, for toilet use, transfers, and bed mobility [redacted] found that the Appellant needed supervision for ADLs. [redacted] found that the Appellant was unstable at times and uses a walker to ambulate in the hall. For 1002, [redacted] found that there was one mention of shoulder pain in the Appellant's chart, but no documented consistent shortness of breath, pain, or debilitating weakness. For 1003, there were no falls reported.

For 1004, [redacted] found that the Appellant takes [redacted] medications, and all of her medications were provided by the facility. For 1005, Appellant was on a regular diet, all her meals were being provided by the facility, she was independent with eating, and there were no weight changes within the past month. Appellant had complained frequently of abdominal pain and nausea, but her meds were adjusted and she had less nausea as of [redacted]. For 1006, [redacted] found that there were no physician visits; no ER visits; and, no order changes within the past 14 days.

For the Behavior categories, 2001-2004 [redacted] found that the Appellant had no wandering, no verbal or physical abuse, and no socially inappropriate behaviors documented. For 3000, [redacted] found that the Appellant's medical records did not show that she 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 [redacted] stated she sent a letter to the Appellant and [redacted] to advise that the facility's decision was upheld. (Exhibit A, Item I).

Appellant's daughter testified the Appellant is doing well and is currently stable due to the good care she has received from the Medical Care Facility. She said the Appellant was eating better and doing better than she did at home. Appellant's daughter said the

Appellant can't remember her medications, and the nurses at the Medical Care Facility were giving them to her when needed. She said the Appellant has severe pain in her upper neck and shoulder. Appellant's daughter said her mother was in a wheelchair, but now uses a walker to get around, but is a bit wobbly. She said her mother refuses to ask for help. She also said the Appellant was very depressed at home and had failure to thrive. Appellant daughter said her mother fell and ended up in the hospital in the first place. Luckily a nurse was present when she fell, and she was given blood at the hospital. Thereafter the Appellant was transferred to the Medical Care Facility for rehabilitation. Appellant daughter testified her mother got better due to the care she received at the Medical Care facility, and is now engaging in activities and socializing with others. She said her mother would not do well in an Adult Foster Care Facility. She believes her mother needs 24 hour care, and she said they cannot afford an assisted living facility.

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, the individual must either be discharged from the nursing facility or become a private pay resident of the nursing facility, or other Medicaid covered services should be considered for that individual in the community. Although the Appellant may be financially eligible for Medicaid covered services, 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] and again on [redacted]. The [redacted] Exception Review upheld the determination made on [redacted] and the Immediate Review upheld the determination made 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 as of [redacted], and again on [redacted]. 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 either [redacted] or [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 the Appellant did not require a Medicaid Nursing Facility Level of Care as demonstrated by the application of the LOCD tool on [redacted] and [redacted]

IT IS THEREFORE ORDERED that:

- The Department's decision is **AFFIRMED.**

William D Bond

William D. Bond
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

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.