STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted],

Appellant

Docket No. 15-010209 NHE
Case No. [redacted]

/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant appeared on her own behalf. [redacted], Appeals Review Officer; [redacted], LOCD Policy Specialist; and [redacted], MDS Coordinator, testified on behalf of the Department of Health and Human Services (Department).

ISSUE

Did the Department properly determine that 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, born [redacted], who is a current resident of Spectrum Rehabilitation Long Term Care.

2. On [redacted], [redacted] 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-Activities of Daily Living.

3. On [redacted], [redacted] conducted another assessment under the Nursing Facility (NF) Level of Care Determination (LOCD) and found Appellant to be ineligible to receive Medicaid reimbursed services in a nursing facility.

4. On [redacted], [redacted] sent Appellant an Advance Action Notice stating that Appellant's final date of Nursing Facility Level Services will be

[redacted] because she no longer qualified for nursing facility level services.

5. On [redacted], Appellant's Request for Hearing was received by the Michigan Administrative Hearing System (MAHS).

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.

A LOCD is required to be done in order to continue services in a nursing facility when there has been a significant change in the resident's condition. If the subsequent LOCD shows the resident is ineligible, the resident will be discharged from the facility. Under the LOCD, there is a look back period of 7 days for Doors 1, 2, 5, and 6 and a 14 day look back period for Doors 3 & 4. To be eligible under Door 7, the resident must have been in the facility for over 1 year, must be in need of a nursing facility level of care to maintain current functional status, and there must be no other community, residential, or informal services available to meet the applicant's needs.

The Department presented testimony and documentary evidence that Appellant did not meet any of the criteria for Doors 1 through 7. The witness from the nursing facility completed a LOCD on [redacted] 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 determined that Appellant was independent for Bed Mobility, and Eating, but needed supervision for Toilet Use and Transferring. 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 determined that Appellant's short-term memory was okay and that her cognitive skills were modified independent. The Department's witness indicated that Appellant scored 15 on the Brief Interview for Mental Status (BIMS) (the highest possible score), but Appellant was determined to be modified independent with regard to cognitive skills because she does have some difficulty making decisions in new situations. 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 determined 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

The Department's witness determined that 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 determined that Appellant did not meet the criteria listed for Door 5 at the time of the assessment. 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 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 been a nursing facility resident for less than one year. According to the LOCD completed by [redacted] on [redacted], 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 Appellant would be sufficient to meet Appellant's needs. The nursing facility witness determined that Appellant's needs could be met in an Assisted Living Facility. Accordingly, Appellant did not qualify under Door 7.

Appellant agreed that she is working with the Department and [redacted] on a discharge plan. She has been accepted at [redacted] Assisted Living and will be moving in [redacted]

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. 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 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].

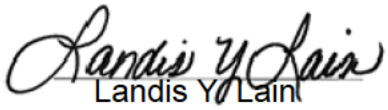
The Department witness testified that Medicaid would continue to pay for services until a decision is rendered by the Administrative Law Judge and services should continue.

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.



Landis Y Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

cc: [redacted]

LYL[redacted]

Date Signed: [redacted]

Date Mailed: [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.