April 8, 2025

[redacted]

RE: [redacted] v. DoHS/BUREAU FOR MEDICAL SERVICES
ACTION NO.:25-BOR-1634

Dear Ms. [redacted]:

Enclosed is a copy of the decision resulting from the hearing held in the above-referenced matter.

In arriving at a decision, the State Hearing Officer is governed by the Public Welfare Laws of West Virginia and the rules and regulations established by the Department of Human Services. These same laws and regulations are used in all cases to assure that all persons are treated alike.

You will find attached an explanation of possible actions you may take if you disagree with the decision reached in this matter.

Sincerely,

Kristi Logan
Certified State Hearing Officer
Member, State Board of Review

Encl: Recourse to Hearing Decision
Form IG-BR-29

cc: Terry McGee, Bureau for Medical Services
[redacted], Ombudsman

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted]

Appellant,

v. **Action Number: 25-BOR-1634**

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES
BUREAU FOR MEDICAL SERVICES,

Respondent.

DECISION OF STATE HEARING OFFICER

INTRODUCTION

This is the decision of the State Hearing Officer resulting from a fair hearing for [redacted]. This hearing was held in accordance with the provisions found in Chapter 700 of the Office of Inspector General Common Chapters Manual. This fair hearing was convened on April 8, 2025.

The matter before the Hearing Officer arises from the January 31, 2025, decision by the Respondent to deny medical eligibility for Long Term Care Medicaid.

At the hearing, the Respondent appeared by Terry McGee, Bureau for Medical Services. Appearing as a witness for the Respondent was Melissa Grega, Acentra Health. The Appellant appeared by her sisters, [redacted]. The witnesses were placed under oath and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Notice of Denial dated January 31, 2025
D-2 Bureau for Medical Services Provider Manual §514.6
D-3 Pre-Admission Screening dated January 29, 2025
D-4 Medication List

Appellant's Exhibits:

None

After a review of the record, including testimony, exhibits, and stipulations admitted into evidence at the hearing, and after assessing the credibility of all witnesses and weighing the evidence in consideration of the same, the Hearing Officer sets forth the following Findings of Fact.

FINDINGS OF FACT

1) The Appellant was a recipient of Long Term Care Medicaid benefits.

2) On January 29, 2025, a Pre-Admission Screening (PAS) was completed for the Appellant to determine continued medical eligibility for Long Term Care Medicaid (Exhibit D-3).

3) The Appellant was awarded deficits in the areas of *vacating in an emergency*, *bathing* and *medication administration* (Exhibit D-3).

4) The Respondent sent a notice on January 31, 2025, advising that the documentation did not reflect at least five deficits at the level required, therefore eligibility for Long Term Care services is denied (Exhibit D-1).

APPLICABLE POLICY

Bureau for Medical Services Policy Manual Chapter 514 explains eligibility for nursing facility services:

514.5.1 Application Process
An application for nursing facility benefits may be requested by the resident, the family/representative, the physician, or a health care facility. The steps involved in approval for payment of nursing facility services are:

- The financial application for nursing facility services is made to the local State office; and
- The medical eligibility determination is based on a physician's assessment of the medical and physical needs of the individual. At the time of application, the prospective resident should be informed of the option to receive home and community-based services. The Pre-Admission Screening (PAS) assessment must have a physician signature dated not more than 60 days prior to admission to the nursing facility. A physician who has knowledge of the individual must certify the need for nursing facility care.

514.5.2 Pre-Admission Screening (PAS)
The PAS for medical necessity of nursing facility services is a two-step process. The first step (Level I) identifies the medical need for nursing facility services based on evaluation of identified deficits and screens for the possible presence of a major mental illness, mental retardation, and/or developmental disability. The second step (Level II) identifies if the individual needs specialized services for a major mental illness, mental retardation, and/or developmental disability.

514.5.3 Medical Eligibility Regarding Pre-Admission Screening

To qualify medically for the nursing facility Medicaid benefit, an individual must need direct nursing care24 hours a day, seven days a week. The State has designated a tool known as the Pre-Admission Screening (PAS) form (Appendix B) to be utilized for physician certification of the medical needs of individuals applying for the Medicaid benefit. An individual must have a minimum of five deficits identified on the PAS. These deficits will be determined based on the review by the State/designee in order to qualify for the Medicaid nursing facility benefit. These deficits may be any of the following (numbers represent questions on the PAS form):

- #24: Decubitus – Stage 3 or 4
- #25: In the event of an emergency, the individual is c) mentally unable or d) physically unable to vacate a building. a) independently and b) with supervision are not considered deficits
- #26: Functional abilities of the individual in the home.
    - Eating: Level 2 or higher (physical assistance to get nourishment, not preparation)
    - Bathing: Level 2 or higher (physical assistance or more)
    - Grooming: Level 2 or higher (physical assistance or more)
    - Dressing: Level 2 or higher (physical assistance or more)
    - Continence: Level 3 or higher (must be incontinent)
    - Orientation: Level 3 or higher (totally disoriented, comatose)
    - Transfer: Level 3 or higher (one person or two persons assist in the home)
    - Walking: Level 3 or higher (one person assists in the home)
    - Wheeling: Level 3 or higher (must be Level 3 or 4 on walking in the home to use, Level 3 or 4 for wheeling in the home.) Do not count outside the home.
- #27: Individual has skilled needs in one of these areas – (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations
- #28: Individual is not capable of administering his/her own medications

This assessment tool must be completed, signed and dated by a physician. The physician's signature indicates "to the best of my knowledge, the patient's medical and related needs are essentially as indicated." It is then forwarded to the State or its designee for medical necessity review. The assessment tool must be completed and reviewed for every individual residing in a nursing facility, regardless of the payment source for services.

DISCUSSION

To qualify medically for the Long Term Care Medicaid, an individual must need direct nursing care 24 hours a day, seven days a week. The Respondent has designated a tool known as the Pre-Admission Screening (PAS) form to be utilized for physician certification of the medical needs of individuals applying for the Medicaid benefit. An individual must have a minimum of five deficits identified on the PAS.

The Appellant underwent an annual medical redetermination for Long Term Care Medicaid in January 2025. The Respondent determined that the Appellant no longer met the medical criteria for Long Term Care Medicaid as she was only awarded three deficits in the areas of *vacating in an emergency, bathing* and *medication administration.*

[redacted], the Appellant's sister, testified that the Appellant has Cerebral Palsy and has resided in the nursing facility for nine years. Ms. [redacted] contended that the Appellant has never been able to cut her own fingernails and toenails and has worn incontinence supplies for the past several years due to urinary incontinence. Ms. [redacted] stated the Appellant only wears pull-on styled pants and shirts that can be pulled over her head as is unable to button her clothes, use a zipper or tie her shoes.

The Appellant's representative provided credible testimony regarding the Appellant's inability to perform grooming tasks due to her diagnosis of Cerebral Palsy and regular bouts of incontinence requiring the use of incontinent supplies. There was no rebuttal testimony provided by the Respondent to dispute the Appellant's representative testimony regarding grooming and urinary incontinence.

Whereas the testimony provided revealed that the Appellant is unable to independently perform grooming tasks and experiences urinary incontinence, the Appellant continues to meet the medical eligibility criteria of five deficits required for Long Term Care Medicaid.

CONCLUSIONS OF LAW

1) An individual must have a minimum of five deficits as derived from the Pre-Admission Screening tool to be medically eligible for Long Term Care Medicaid.

2) The Appellant was awarded three deficits on the January 2025 Pre-Admission Screening.

3) Credible testimony revealed the Appellant has deficits in grooming and urinary incontinence.

4) The Appellant continues to meet the medical eligibility criteria for Long Term Care Medicaid.

DECISION

It is the decision of the State Hearing Officer to **reverse** the decision of the Respondent to deny medical eligibility for Long Term Care services.

ENTERED this 8th day of April 2025.

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Kristi Logan
Certified State Hearing Officer