July 16, 2025

[redacted]

RE: [redacted] v. WV DoHS/BMS
ACTION NO.: 25-BOR-2258

Dear [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 ensure 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,

Lori Woodward, J.D.
Certified State Hearing Officer
Member, State Board of Review

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

cc: Terry McGee/Kesha Walton, WV DoHS/BMS
[redacted]

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 25-BOR-2258**

WV 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 West Virginia Office of Inspector General Common Chapters Manual. This fair hearing was convened on July 15, 2025.

The matter before the Hearing Officer arises from the Respondent's decision to deny medical eligibility for Long Term Care (LTC) Medicaid as outlined in the Notice dated June 2, 2025.

At the hearing, the Respondent appeared by Terry McGee, Program Manager, Bureau of Medical Services (BMS). Appearing as a witness for the Respondent was RN Melissa Grega, Nurse Reviewer, Acentra Health. The Appellant was present and was represented by her sister, [redacted] Appearing as a witness for the Appellant was [redacted] social worker. All witnesses were placed under oath and the following documents were admitted into evidence.

Department's Exhibits:

- D-1 Notice of Denial for Long-Term Care (Nursing Facility) dated June 2, 2025
- D-2 Acentra Policy, Chapter 514, §514.5.3 (excerpt)
- D-3 Pre-Admission Screening (PAS) form dated June 1, 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 currently resides at [redacted] and applied for Long Term Care (LTC) Medicaid.

2) A Pre-Admission Screening (PAS), the assessment tool used to determine medical eligibility for LTC Medicaid, was completed for the Appellant on June 1, 2025, by [redacted]. (Exhibit D-3)

3) At the time of the June 2025 PAS, the Appellant was assessed to have substantial deficits in the areas of *Medication Administration, Grooming, and Bathing*. (Exhibit D-3)

4) On June 2, 2025, the Respondent sent the Appellant notification of the denial of her LTC Medicaid application as only three out of the five required substantial deficits were assessed on the June 2025 PAS. (Exhibit D-1)

5) The Appellant has a diagnosis of, and is being treated for, schizophrenia.

APPLICABLE POLICY

Bureau of Medical Services (BMS) Manual, Chapter 514, 514.5.1, Application Procedures: 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 DHHR 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.

BMS Manual, Chapter 514, §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.

BMS Manual, Chapter 514, §514.5.3 Medical Eligibility Regarding the Pre-Admission Screening, in part: To qualify medically for the nursing facility Medicaid benefit, an individual must need direct nursing care 24 hours a day, seven days a week. The BMS 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 a BMS/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 mentally or physically unable to vacate a building. Independently and 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…)
    - 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 person assist in the home)
    - Walking: Level 3 or higher (one person assistance in the home)
    - Wheeling: Level 3 or higher
- #27: Individual has skilled needs in one of these areas: suctioning, tracheostomy, ventilator, parenteral fluids, sterile dressings, or 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 BMS 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

Approval for the Respondent's LTC (Nursing Home) Medicaid program involves financial and medical determination of eligibility. The financial eligibility determination is made by the Department of Human Services (DoHS) Bureau of Family Assistance (BFA). The medical eligibility determination is made by the DoHS Bureau for Medical Services (BMS). On appeal is the Respondent's June 2, 2025 finding of medical ineligibility for the LTC Medicaid program.

To qualify medically for the LTC Medicaid benefit, an individual must need direct nursing care 24 hours a day, seven days a week. The BMS 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. These deficits will be determined based on the review by a BMS/designee in order to qualify for the LTC Medicaid benefit.

The Appellant is currently a resident of the [redacted] in REMOVED, West Virginia who underwent a PAS assessment on June 1, 2025. The findings from this assessment were recorded on a Pre-Admission Screening (PAS) document completed by a physician from the facility, [redacted]. This document was reviewed by the Respondent's nurse reviewer to determine the number of deficits that met the LTC Medicaid policy severity criteria for medical eligibility. At least five severe deficits are required to establish medical eligibility for LTC Medicaid. The Appellant had three identified deficits that met the severity level established by policy on her June 2025 PAS: *Medication Administration*, *Grooming*, and *Bathing*. On June 2, 2025, the Respondent sent the Appellant notification that her application for LTC Medicaid had been denied based on not meeting at least five areas of care needs (deficits) that met the severity criteria for medical eligibility. The Appellant contests the Respondent's decision.

The Respondent had to prove by a preponderance of evidence that the Appellant's eligibility for LTC Medicaid was correctly denied because the Appellant did not have severe deficits in at least five areas at the time of the June 1, 2025 PAS.

Nurse Grega, testified that the June 2025 PAS, upon which the Respondent's decision was made, failed to show at least five deficits that met the severity level needed for medical eligibility for LTC. The Appellant's representative, [redacted] stated that she believed that the Appellant should have been awarded additional deficits in the areas of *Eating*, *Orientation*, and *Communication*. The June 2025 PAS assessed the Appellant as a Level 1 – Self/Prompting for *Eating*, a Level 1 – Oriented for *Orientation*, and a Level 1 – Not Impaired for *Communication*.

Neither [redacted] the Appellant, nor the witness, [redacted] provided any testimony as to these additional areas that [redacted] believed should have been awarded. Instead, the testimony provided showed that the Appellant has improved while she has been a resident at [redacted]. [redacted] surmised that the Appellant's improvement is based upon the management of the Appellant's medications for the treatment of her schizophrenia. [redacted] testified that she is concerned that without the constant medication management, the Appellant will once again have issues with her activities of daily living which necessitated her admission to the nursing facility. It is noted that *Medication Administration* was found to be a substantial deficit on the June 2025 PAS and was a functional area the Respondent's representative conceded.

Policy requires a Level 2 or higher (physical assistance to get nourishment) for the area of *Eating*, and a Level 3 or higher (totally disoriented, comatose) for *Orientation*. Communication is not an identified area of functionality that is considered in establishing medical eligibility. In reviewing the evidence provided, there were no other areas of functional deficits that could be awarded to the Appellant. It was noted by [redacted] that the June PAS erroneously indicated "N/A" on Question #44 and #45. [redacted] testified that the Appellant is currently receiving treatment for her schizophrenia and that previously the Appellant was hospitalized due to her schizophrenia. [redacted] had questions regarding a Level 2 screening. Nurse Grega testified that a Level 2 screening is applied if mental health issues are causing physical issues. Nurse Grega stated that

those individuals are generally deemed not appropriate for nursing home care and would require a more appropriate place so those issues could be properly addressed.

The Board of Review (BOR) does not have the authority to grant eligibility beyond those criteria established by the policy or regulations. Instead, the BOR is tasked to determine whether the Respondent followed the policy and regulations in making its determination. The PAS did not indicate the presence of any functioning deficits other than *Medication Administration*, *Grooming*, and *Bathing* at the time of the Respondent's June 2, 2025 denial of the Appellant's medical eligibility for the LTC Medicaid program. No additional policy-defined deficits were established at the hearing.

Whereas the preponderance of the evidence revealed the Appellant did not have functioning deficits in at least five policy-identified areas of functioning at the time of the June 2025 PAS, the Respondent's decision to deny the Appellant medical eligibility for LTC is affirmed.

CONCLUSIONS OF LAW

1) To medically qualify for LTC Medicaid benefits, an individual must have a minimum of five deficits identified on the Pre-Admission Screening form.

2) The preponderance of evidence showed that the Appellant had three identified policy-defined deficits at the time her June 2025 PAS was completed.

3) No additional policy-defined deficits were established at the hearing.

4) Because the Appellant did not have at least five deficits identified at the time of her June 2025 PAS, the Respondent must deny the Appellant's medical eligibility for LTC Medicaid benefits.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to deny LTC Medicaid benefits.

ENTERED this 16th day of July 2025.

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Lori Woodward, Certified State Hearing Officer