July 30, 2025

[redacted]

RE: [redacted] v. WV DoHS
ACTION NO.: 25-BOR-2355

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,

Pamela L. Hinzman
State Hearing Officer
Member, State Board of Review

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

cc: Terry McGee, Bureau for Medical Services

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 25-BOR-2355**

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 July 23, 2025.

The matter before the Hearing Officer arises from the June 23, 2025, decision by the Respondent to deny Long-Term Care Medicaid benefits.

At the hearing, the Respondent appeared by Terry McGee, Program Manager for Long-Term Care Facilities, Bureau for Medical Services. Appearing as a witness for the Respondent was Melissa Grega, Nurse Reviewer, Acentra Health. The Appellant appeared by her daughter, [redacted] and her son-in-law, [redacted]. The witnesses were placed under oath and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Notice of Denial dated June 23, 2025
D-2 Acentra Health Policy Chapter 514.5
D-3 Pre-Admission Screening completed on June 18, 2025
D-4 Appellant's 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 applied for Long-Term Care Medicaid benefits.

2) On June 18, 2025, a Pre-Admission Screening (PAS) was completed for the Appellant to determine medical eligibility for Long-Term Care Medicaid (Exhibit D-3).

3) The Appellant was awarded four deficits on the PAS because she requires physical assistance with bathing, dressing, and grooming, and two-person assistance with transferring (Exhibit D-3).

4) The Respondent sent the Appellant a notice on June 23, 2025, advising that documentation submitted for review did not reflect at least five deficits at the level required, therefore eligibility for Long-Term Care Medicaid was 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 care 24 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 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 a medical evaluation for Long-Term Care Medicaid in June 2025. The Respondent determined that the Appellant did not meet medical criteria for Long-Term Care Medicaid as she was only awarded four deficits in the areas of bathing, dressing, grooming, and transferring.

The Appellant's daughter, [redacted] testified that the Appellant, age 96, suffers from osteoporosis and is "doubled over" from the condition. As a result, the Appellant has problems with balance and would require physical assistance to vacate a building in the event of an emergency. The Appellant had been rated as requiring prompting or supervision to vacate on the PAS. Although the Appellant does not currently take medication for osteoporosis, the Respondent's representatives provided no testimony to counter [redacted] contention that the Appellant would be unable to vacate during an emergency without physical assistance. The Appellant's son-in-law, [redacted] questioned why the Appellant did not receive a deficit in the functional area of wheeling. Melissa Grega, Nurse Reviewer with Acentra, testified that an individual must be rated at Level 3 or higher (requiring one or two-person physical assistance) in walking to receive a deficit in the functional area of wheeling.

As the Appellant's daughter provided credible testimony that her mother would require physical assistance to exit a building in the event of an emergency, and the Appellant had received a PAS deficit for requiring two-person physical assistance with transferring, the Appellant is awarded a deficit for inability to vacate in the event of an emergency.

The addition of one deficit brings the Appellant's total number of functional deficits to five and renders her medically eligible for the Long-Term Care Medicaid Program.

CONCLUSIONS OF LAW

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

2) The Appellant was awarded four deficits on her June 2025 Pre-Admission Screening.

3) Based on information provided during the hearing, the Appellant is awarded one additional deficit for inability to vacate the building in the event of an emergency.

4) The Appellant meets medical eligibility criteria for the Long-Term Care Medicaid Program.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the action of the Respondent to deny Long-Term Care Medicaid benefits.

ENTERED this 30th day of July 2025.

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Pamela L. Hinzman
State Hearing Officer