July 30, 2025

[redacted]

RE: [redacted] v. DoHS/BUREAU FOR MEDICAL SERVICES
ACTION NO.: 25-BOR-2399

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,

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

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

cc: Terry McGee/Kesha Walton, Bureau for Medical Services

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 25-BOR-2399**

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 30, 2025.

The matter before the Hearing Officer arises from the June 17, 2025, decision by the Respondent to deny medical eligibility for Long Term Care services.

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

Department's Exhibits:

D-1 Notice of Denial dated June 17, 2025
D-2 Nursing Facility Policy §514.5
D-3 Pre-Admission Screening dated June 11, 2025
D-4 Order Summary Report

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 is a resident at [redacted].

2) The Appellant applied for Long Term Care Medicaid benefits in June 2025.

3) On June 11, 2025, a Pre-Admission Screening (PAS) was completed for the Appellant to determine medical eligibility for Long Term Care Medicaid (Exhibit D-3).

4) The Appellant was awarded no deficits on the June 2025 PAS (Exhibit D-3).

5) The Respondent sent a notice on June 17, 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 services paid for by 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 was evaluated for medical eligibility for Long Term Care services on June 11, 2025. The PAS, completed and signed by the Appellant's physician, reflected no deficits for the Appellant. The Appellant's representative, [redacted], contended that the Appellant should have

received deficits in the areas of *vacating in an emergency, eating, bathing, dressing, walking, transferring* and *medication administration*.

Vacating in an Emergency

The Appellant was assessed as requiring supervision to *vacate in an emergency*. [redacted] testified that the Appellant has no support in the community and if discharged from the facility, there would be no one to supervise him to ensure he vacates in an emergency. To receive a deficit in *vacating*, the Appellant would have to be mentally or physically unable to vacate. The testimony provided did not indicate that the Appellant was physically or mentally unable to vacate and was correctly assessed as requiring supervision.

Eating

The Appellant was assessed as a Level 1, self/prompting, in *eating*. [redacted] stated that the Appellant is unable to prepare meals and would not have a healthy diet without assistance. To receive a deficit in *eating*, an individual must be unable to obtain nourishment without physical assistance. Assistance with meal preparation does not constitute physical assistance with *eating* therefore a deficit cannot be awarded in this area.

Bathing and Dressing

The Appellant was assessed as a Level 1, self/prompting, in *bathing* and *dressing*. [redacted] testified that the Appellant cannot tolerate exertion due to a heart condition. No specific testimony was provided to determine if the Appellant requires physical assistance to bathe and dress. To receive a deficit in *bathing* and *dressing*, an individual would require physical assistance to perform these activities. The testimony provided failed to establish that the Appellant receives physical assistance in *bathing* and *dressing* and was correctly assessed as a Level 1.

Transferring and Walking

To receive a deficit in the areas of *transferring* and *walking*, an individual must be assessed as Level 3, requiring hands-on physical assistance from another person. The Appellant was assessed as Level 1, independent. [redacted] testified that the Appellant has shortness of breath and is unsteady on his feet and would be unable to transfer or walk safely. No testimony was provided to establish that the Appellant requires physical assistance from another person to transfer or ambulate. The Appellant was correctly assessed as Level 1 in *transferring* and *walking*.

Medication Administration

The Appellant was assessed as requiring prompting/supervision with *medication administration*. [redacted] testified that the Appellant cannot safely administer medications due to mental illness and decline in his cognitive abilities. [redacted] stated the Appellant cannot recall his medical history or what medications he currently takes and would be unable to correctly take his medications as prescribed. To receive a deficit in *medication administration*, an individual must be physically unable to administer medications, whether orally or by injection. The testimony provided supported that the Appellant was correctly assessed as requiring prompting/supervision in *medication administration*.

According to the Order Summary submitted with the PAS, the Appellant's nails are trimmed by a nurse (Exhibit D-4). Because the Appellant requires physical assistance with nail trimming, the

Appellant should have been assessed as Level 2 in *grooming* and a deficit should have been awarded.

Based on the testimony and documentation provided, the Appellant was found to be demonstrating a deficit in the area of *grooming*. Whereas the Appellant has only one deficit and policy requires the presence of at least five deficits as derived from the PAS, the Respondent's decision to deny medical eligibility for Long Term Care services is affirmed.

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 received no deficits on the June 2025 Pre-Admission Screening.

3) The evidence and testimony established the Appellant has a deficit in *grooming*.

4) With only one deficit, the Appellant does not meet the medical eligibility criteria for Long Term Care Medicaid.

DECISION

It is the decision of the State Hearing Officer to **uphold** the decision of the Respondent to deny Long Term Care services for the Appellant for failure to meet medical eligibility criteria.

ENTERED this 30th day of July 2025.

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Kristi Logan
Certified State Hearing Officer