September 25, 2025

[redacted]

RE: [redacted] v. WVDoHS/BMS
ACTION NO.: 25-BOR-2594

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,

Todd Thornton
State Hearing Officer
Member, State Board of Review

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

cc: Terry McGee, II, Department Representative
Kesha Walton, Department Representative
[redacted] Appellant Representative

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted]

Appellant,

v. **Action Number: 25-BOR-2594**

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 September 11, 2025, upon a timely appeal filed on August 7, 2025.

The matter before the Hearing Officer arises from the August 4, 2025 decision by the Respondent to deny Long Term Care Medicaid due to medical eligibility findings.

At the hearing, the Respondent appeared by Terry McGee, II. Appearing as a witness for the Respondent was Melissa Grega. The Appellant was not present but was represented by [redacted] temporary guardian for the Appellant. [redacted] appeared as witnesses for the Appellant. All witnesses were placed under oath, and the following documents were admitted into evidence.

EXHIBITS

Department's Exhibits:

D-1	Notice of decision, dated August 4, 2025
D-2	Excerpted policy printout
D-3	Pre-Admission Screening (PAS) assessment form, dated August 4, 2025

D-4 Medication list

Appellant's Exhibit:

A-1 Printed photographs of the Appellant
Medical records regarding the Appellant

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 (LTC-M) for nursing facility placement.

2) An assessment of the Appellant's medical eligibility for LTC-M was conducted on August 4, 2025.

3) The findings from this assessment were documented in a Pre-Admission Screening (PAS) form. (Exhibit D-3)

4) The August 4, 2025 PAS (Exhibit D-3) listed [redacted] as the nurse reviewer of the document and included her electronic signature.

5) The Respondent mailed the Appellant a notice (Exhibit D-1), dated August 4, 2025, advising that his application for LTC-M was denied because "Documentation does not reflect that you have five (5) deficits at the level required…"

6) This notice (Exhibit D-1) further advised that the Appellant's PAS "…reflected deficiencies that meet the severity criteria in 4 areas…"

7) The notice (Exhibit D-1) listed deficits for the Appellant in the areas of *medication administration*, *incontinence*, *orientation*, and emergency assistance with *vacating*.

8) The Appellant's representative contended the Appellant should have received deficits in *transferring*, *grooming*, *bathing*, *dressing*, *walking*, and *skilled needs* (or professional and technical care needs).

9) Additional PAS documents from July 2025 assessments of the Appellant were submitted for consideration. (Exhibit A-1, pp. 65 – 76; pp. 91 – 101; pp. 541 – 549)

10) The July 2025 PAS documents were not reviewed by a nurse reviewer or lacked a signature from a nurse reviewer. (Exhibit A-1, pp. 65 – 76; pp. 91 – 101; pp. 541 – 549)

11) The July 2025 PAS documents were not the basis of the Respondent's decision. (Exhibit A-1, pp. 65 – 76; pp. 91 – 101; pp. 541 – 549)

12) The July 2025 PAS documents (Exhibit A-1, pp. 65 – 76; pp. 91 – 101; pp. 541 – 549) were less timely than the August 4, 2025 (Exhibit D-3) PAS document.

13) Printed photographs of the Appellant (Exhibit A-1, pp. 2 – 6) and his hospital room do not show a need for at least one-person physical assistance with *walking*.

14) The Appellant is independent in the area of *walking*. (Exhibit D-3)

15) Printed photographs of the Appellant (Exhibit A-1, pp. 2 – 6) and his hospital room do not show a need for at least one-person physical assistance with *transferring*.

16) The Appellant is independent in the area of *transferring*. (Exhibit D-3)

17) Printed photographs of the Appellant (Exhibit A-1, pp. 2 – 6) and his hospital room do not show a need for physical assistance with *grooming*.

18) The Appellant is Level 1, or "self/prompting" in the areas of *grooming*, *bathing*, and *dressing*. (Exhibit D-3)

19) The *skilled needs* proposed as a deficit for the Appellant were regarding physical therapy and occupational therapy.

20) By policy, physical therapy and occupational therapy are not *skilled needs* counted as potential deficits.

APPLICABLE POLICY

Bureau for Medical Services Provider Manual, Chapter 514, § 514.5.1, provides:

> 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 the 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.

Bureau for Medical Services Provider Manual, Chapter 514, § 514.5.3, provides:

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.

o Eating: Level 2 or higher (physical assistance to get nourishment, not preparation)

o Bathing: Level 2 or higher (physical assistance or more)

o Grooming: Level 2 or higher (physical assistance or more)

o Dressing: Level 2 or higher (physical assistance or more)

o Continence: Level 3 or higher (must be incontinent) o Orientation: Level 3 or higher (totally disoriented, comatose)

o Transfer: Level 3 or higher (one person or two persons assist in the home)

o Walking: Level 3 or higher (one person assists in the home)

o 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.

The PAS may be submitted to the appropriate Utilization Management Contractor (UMC) electronically through a secure website. The faxing option will still be available and is entered into the direct data entry (DDE) by the UMC. When a PAS is submitted electronically, the physician has two options for providing attestation that the patient's medical and related needs are accurate as indicated with their signature:

1. If the physician has the capability for electronic signature (an actual version of their signature, such as when one signs for a credit card or package, the signature is created electronically), not just a typed version of their name; OR

2. Box #39 will be checked on the PAS which certifies the physician has completed this PAS (his or her name will be typed out). Then the PAS MUST be printed off and the physician's physical signature (such as the signature you see when one signs a letter) must be added. The signed page is attached to the electronic record and/or sent to the nursing facility accepting the resident.

On either option for signature, the date is automatically populated and that will be the date for the start of Medicaid reimbursement for services, if the individual meets financial eligibility for the nursing facility benefit. However, the PAS must be signed either electronically or physically by the physician in order for the PAS to be valid.

If an actual written signature either from the resident or responsible party cannot be obtained, verbal consent is necessary. The individuals obtaining verbal consent must sign/date along with the witness who also signs/dates. However, the entity completing the PAS MUST obtain an actual signature from the resident or responsible party on the hard copy of the PAS which will be the PAS on file with the nursing facility and available for review upon request.

Each nursing facility must have a signed, original pre-admission screening tool to qualify the individual for Medicaid benefits and to meet the federal Pre-Admission Screening and Resident Review (PASRR) requirements. Should the receiving nursing facility fail to obtain an approved assessment with an original signature from the resident or responsible party prior to admission of a Medicaid eligible individual, the Medicaid program cannot pay for services rendered at the nursing facility for that individual. The individual cannot be charged for the cost of care during the non-covered period.

A Medicaid member, who had Medicare and reaches the 21st day of Medicare Coverage and will be converting to Medicare Part A coverage with Medicaid as the co-pay, does not need a new PAS as long as the facility has a current PAS that is no more than 60 days old. If the individual has not been a member of Medicaid

upon admission to the nursing facility, a new PAS will need to be completed before the Medicare benefit has ended and the Advanced Beneficiary Notice of Medicare Non-Coverage has been issued. This ensures proper placement if circumstances warrant long-term placement for the individual in the nursing facility after Medicaid becomes the primary payer.

A new medical assessment must be completed for Medicaid medical eligibility for the nursing facility resident for all of the following situations:

- Application for the Medicaid nursing facility benefit;
- Resident transfers from one nursing facility to another nursing facility, even if the transfer is within the same corporation;
- Resident returns to the same nursing facility from any healthcare setting other than an acute care hospital;
- Resident transfers to an acute care hospital, then to a hospital-based skilled nursing unit, and then returns to the original nursing facility;
- Resident converts from private pay or any other payer to Medicaid; or
- Expiration of the current PAS due to time limitation.

DISCUSSION

The Appellant has appealed the decision of the Respondent to deny his application for Long Term Care Medicaid (LTC-M) based on medical eligibility findings. The Respondent must prove by a preponderance of the evidence that it correctly denied the Appellant's application.

Medical eligibility for LTC-M is established based on the findings of a medical assessment recorded on an assessment tool known as a Pre-Admission Screening (PAS) form. The PAS must include a physician signature certifying medical necessity. The PAS must be reviewed by the Respondent's nurse reviewer. The Respondent presented arguments regarding an August 4, 2025 notice of LTC-M denial based on an August 4, 2025 PAS. The Appellant presented three additional PAS documents from July 2025.

Policy requires a timely assessment of medical necessity for LTC-M and specifies a 60-day window for relying on a given PAS. The July 2025 PAS documents are not untimely but are not as reliable as the current August 2025 PAS. The August 2025 PAS clearly shows a nurse reviewer by name and includes her electronic signature. None of the July PAS documents show the required nurse review "by a BMS/designee in order to qualify for the Medicaid nursing facility benefit." (BMS Provider Manual, Chapter 514, § 514.5.3) Two of the July 2025 PAS documents were prepared on the same date with different findings, suggesting at least one was prepared in error. Finally, because each PAS assessment is a distinct set of medical eligibility findings existing at the time of the assessment, the deficits noted therein are not cumulative; a deficit from an outdated PAS does not carry over to a current assessment or cancel the findings of a current assessment. Therefore, the August 2025 PAS is the only current and reliable PAS submitted as evidence in the hearing.

Printed photographs of the Appellant were presented to demonstrate the additional proposed deficits for the Appellant. The photographs appear to present the Appellant in his hospital bed and show a document hanging in his hospital room. The photographs show the Appellant's toenails and his beard. The photographs do not distinguish between an inability to independently perform grooming tasks and refusal to perform those tasks, or, in the case of the Appellant's beard, a possible grooming choice. The August 2025 PAS findings that the Appellant can perform grooming tasks by himself or with prompting (a Level 1 designation that does not produce a deficit) is more convincing than photographs of the Appellant. The Respondent correctly determined the Appellant does not require physical assistance with *grooming* and did not establish a deficit in that area.

The Appellant proposed a deficit for *skilled needs* in the form of physical therapy and occupational therapy. These arguments are irrelevant because policy does not include these therapy types in the set of skilled needs corresponding to a deficit. The Respondent correctly determined the Appellant did not establish a deficit for *skilled needs*.

The Appellant provided medical records from several years prior to the Appellant's August 2025 assessment. In the same way that outdated PAS documents are not as reliable as the current PAS, outdated records are not as reliable as the current PAS for establishing the Appellant's current medical necessity. There was no expert testimony to interpret medical documents, test results, or provide context to notes to allow past medical information to inform current medical necessity.

Printed photographs also did not establish the Appellant required the level of assistance with *walking* or the level of assistance with *transferring* necessary to receive deficits. One photograph shows a document hanging in the Appellant's hospital room. Under a heading titled "Plan for me today," and a subheading titled "Mobility/Activity," boxes are marked next to "Walk" and "Up with assistance." Without appropriate testimony this cannot be interpreted to mean the Appellant is unable to walk independently. Even the box marked for "Up with assistance" could describe an abundance of caution on the part of the hospital that exceeds the Appellant's actual medical needs with transferring. If adequate, appropriate testimony had been offered to support the document, its reliability would be greater, but its relevance would be limited to its date – August 12, 2025 – after the August 4, 2025 decision under appeal. The August 2025 PAS is more reliable than these photographs regarding the Appellant's ability in the areas of *walking* and *transferring*. The Appellant was assessed as Level 1, or independent, with regard to *walking* and *transferring*, which does not result in deficit findings. The Respondent's findings regarding *walking* and *transferring* are correct.

Testimony was offered that the Appellant refuses to perform *bathing* and *dressing* tasks. This testimony, in conjunction with a documented medical opinion, was offered as an argument in support of deficits in *bathing* and *dressing*. Unqualified medical opinions offered in the Appellant's evidence were not considered. At page 44 of the Appellant's exhibit, [redacted] MD, notes (emphasis in original), "I understand that pt has not cooperated with some evaluations required to determine the level of care he will need outside of the hospital, such as PT/OT evals. It is my strong recommendation that if a pt cannot understand the need to cooperate in the evaluation, that likely reflects that the patient does <u>not</u> have those skills, and will need assistance

with them outside of the hospital." Although [redacted] may be willing to make this leap, the Respondent cannot approve services based on a fact that "likely reflects" eligibility. Without testimony it is unclear if she is asserting that a refusal to cooperate passively establishes eligibility for a deficit or that the "inability to understand the need to cooperate in the evaluation" passively establishes a deficit. It is also unclear whether [redacted] is referring narrowly to only physical therapy and occupational therapy needs, or more broadly. There is no need for a medical eligibility process at all if an applicant can establish all deficits by simply refusing to participate in an assessment. Medical eligibility policy is centered around functional abilities, not the performance level the individual chooses. If the Respondent were to accept a refusal to perform relevant tasks as equivalent to an inability to perform those tasks, the Respondent would be assessing an applicant's medical preferences, not their medical needs. Refusal to perform bathing and dressing tasks does not establish a requirement for physical assistance in *bathing* and *dressing* (the threshold necessary to receive a deficit in those areas). The August 2025 PAS findings are the most convincing regarding the Appellant's functional abilities, which established the Appellant as capable of performing *bathing* and *dressing* tasks by himself or with prompting. The Respondent correctly determined the Appellant did not qualify for deficits in these areas based on the Level 1 assessments.

Based on the reliable testimony and evidence offered at the hearing, the Respondent correctly determined the Appellant had insufficient deficits to establish medical eligibility for LTC-M and correctly denied the Appellant's application on that basis.

CONCLUSIONS OF LAW

1) Because the August 4, 2025 PAS assessment form clearly showed that it was reviewed by the Respondent, or its nurse/designee, it is more reliable than other PAS documents presented which appear to lack such a review.

2) Because photographs after the Respondent's decision lack testimonial support to establish medical eligibility retroactively, the August 4, 2025 PAS assessment is more reliable.

3) Because outdated medical records of the Appellant lack testimonial support to bridge the gap between past medical needs and current medical needs, the August 4, 2025 PAS assessment is more reliable.

4) Because policy requires applicants establish medical eligibility for the nursing facility Medicaid benefit by demonstrating a need for "…direct nursing care 24 hours a day, seven days a week," the August 4, 2025 PAS findings are more reliable than speculative testimony and evidence that a refusal to execute functional abilities is equivalent to an inability to perform functional abilities at a given level.

5) Because the August 4, 2025 PAS assessment of the Appellant revealed four (4) deficits and LTC-M policy requires five (5) deficits, the Appellant did not meet the medical eligibility criteria required to qualify for the Medicaid nursing facility benefit.

6) Because the Appellant did not meet the appropriate medical eligibility criteria, the Respondent correctly denied the Appellant's application for LTC-M.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's denial of Long Term Care Medicaid (LTC-M) due to medical eligibility findings.

ENTERED this _____ day of September 2025.

_____

Todd Thornton
State Hearing Officer