October 8, 2025

[redacted]

RE: [redacted] v. WV DoHS
ACTION NO.: 25-BOR-2659

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
Kesha Walton, Bureau for Medical Services
[redacted]

**WEST VIRGINIA OFFICE OF INSPECTOR GENERAL**
**BOARD OF REVIEW**

[redacted],

**Appellant,**

**v.** **Action Number: 25-BOR-2659**

**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 October 7, 2025.

The matter before the Hearing Officer arises from the August 13, 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 was present for the hearing and was represented by his daughter/Medical Power of Attorney, [redacted]. Appearing as witnesses for the Appellant were [redacted] Social Worker, [redacted], Interim Director of Nursing, [redacted] Licensed Practical Nurse, [redacted]. The witnesses were placed under oath and the following documents were admitted into evidence.

**Department's Exhibits**:

D-1 Notice of Denial dated August 13, 2025
D-2 Acentra Health Policy Chapter 514.5
D-3 Pre-Admission Screening completed on August 13, 2025
D-4 [redacted] Medication Review 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 of [redacted].

2) The Appellant underwent a new Pre-Admission Screening (PAS) to reevaluate his medical eligibility for Long-Term Care Medicaid as part of a state surveyor review process (Exhibit D-3).

3) On August 13, 2025, a Pre-Admission Screening (PAS) was completed for the Appellant to determine medical eligibility for Long-Term Care Medicaid (Exhibit D-3).

4) Section 18 of the PAS form is check-marked to indicate that the facility received verbal consent from the Appellant for the release of medical information by the physician to the Department of Human Services or its representative to determine his need for appropriate services (Exhibit D-3).

5) [redacted] Social Worker at [redacted], completed the PAS based on information in the Appellant's chart and a physician "signed off" on information contained in the document (Exhibit D-3).

6) The Appellant was awarded one deficit on the PAS (total care with bathing) (Exhibit D-3).

7) The Respondent sent the Appellant a notice on August 13, 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…
>
> 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.

## 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. 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.

The Appellant testified that he did not provide verbal consent for the completion of the August 13, 2025, PAS and was unaware that the new PAS was being completed. [redacted] Social Worker with [redacted], testified that after the PAS was completed and the denial was received by the facility, she visited the Appellant's room to determine whether he wished to appeal the decision. [redacted] stated that she considered that relay of information as the Appellant's verbal consent. The Appellant contended that he was unaware that a PAS had been completed until the date [redacted] assisted him with the appeal paperwork.

Terry McGee, Program Manager for Long-Term Care Facilities with the Bureau for Medical Services, testified that if the Appellant did not provide verbal consent for completion of the PAS, the PAS is considered invalid.

[redacted] the Appellant's daughter, testified that her father started demonstrating symptoms of a possible stroke around August 24, 2025, and addressed several functional areas in which she believes the Appellant requires assistance, including eating, medication administration, vacating the building in the event of an emergency, communication, and grooming.

As the Appellant did not provide verbal consent for completion of the August 2025 PAS, the Respondent's decision to deny Long-Term Care Medicaid benefits cannot be affirmed.

## CONCLUSIONS OF LAW

1) Policy states that written or verbal consent is required from nursing facility residents or their representatives when a PAS is completed.

2) There is no evidence that written or verbal consent was received from the Appellant or his representative prior to completion of his August 2025 PAS.

3) As the Appellant did not provide consent for completion of the August 2025 PAS, the PAS is invalid and a valid PAS must be completed.

## DECISION

It is the decision of the State Hearing Officer to **REVERSE** the action of the Respondent to deny Long-Term Care Medicaid benefits. The issue is **REMANDED** to the Respondent to allow for completion of a valid PAS.

**ENTERED this 8th day of October 2025.**

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**Pamela L. Hinzman**
**State Hearing Officer**