November 26, 2025

[redacted]

RE: [redacted] v. WVDoHS
ACTION NO.: 25-BOR-3035

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: Sean Hamilton, Department Representative
Drema Berry, Department Representative
[redacted]

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted]

Appellant,

v. **Action Number: 25-BOR-3035**

WEST VIRGINIA DEPARTMENT OF
HUMAN SERVICES
BUREAU FOR FAMILY ASSISTANCE,

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 November 13, 2025, upon a timely appeal filed on October 7, 2025.

The matter before the Hearing Officer arises from a determination by the Respondent regarding Long-Term Care Medicaid non-reimbursable medical expenses (NRME), or "remedial" expenses for the Appellant. The Respondent failed to provide a notice detailing this action, which was likely part of the required notices regarding post-eligibility calculations or the Appellant's contribution toward their cost of care.

At the hearing, the Respondent appeared by Bryce Legg and Sean Hamilton. The Appellant was not present but was represented by [redacted], her nursing facility representative. All witnesses were sworn and the following documents were admitted into evidence.

EXHIBITS

Department's Exhibits:

D-1 Board of Review hearing decision, 25-BOR-[redacted]
Decision date: May 15, 2025

D-2	Excerpted email chain (incomplete) Messages dated June 13, 2025 – September 12, 2025 [redacted] transaction report/itemization of the Appellant's NMRE
D-4	Excerpted email chain (incomplete) Messages dated September 23, 2025
D-5	Email chain Messages dated September 23, 2025 – September 30, 2025
D-6	Hearing request form, signed October 2, 2025
D-7	Long Term Care Medicaid application form, signed May 30, 2025 Financial verifications Pre-Admission Screening (PAS) form, signed May 27, 2025 PAS form, signed September 9, 2024

Appellant's Exhibits:

None

* D-3 was not admitted due to contents violating the confidentiality of another, unrelated Respondent case.

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 Medicaid, specifically Long-Term Care (LTC) Medicaid for Nursing Facility services, on September 6, 2024. (Exhibit D-1)

2) The Appellant was assessed to determine her medical need for nursing facility services in September 2024. The findings from this assessment were recorded on a Pre-Admission Screening (PAS) form, signed by a physician on September 9, 2024. (Exhibit D-7)

3) The Respondent denied the Appellant's September 2024 application. (Exhibit D-1)

4) The Appellant requested a hearing regarding the Respondent's denial. (Exhibit D-1)

5) The Board of Review issued a decision, dated May 15, 2025, affirming the Respondent's denial of the Appellant's LTC Medicaid application dated September 6, 2024. (Exhibit D-1)

6) The decision (Exhibit D-1) included a *Recourse to Administrative Hearing Decision* form.

7) The Appellant applied for LTC Medicaid for nursing facility services on May 30, 2025. (Exhibit D-7)

8) The Appellant's agent reported that the Appellant entered the nursing facility [redacted] on May 30, 2025. (Exhibit D-7)

9) The Appellant was assessed to determine her need for a nursing facility level of care in May 2025, and the findings from this assessment were recorded on a PAS (Exhibit D-7), signed by a physician on May 27, 2025.

10) The Respondent approved the Appellant's May 2025 LTC Medicaid application.

11) The Respondent did not provide a notification letter detailing the May 2025 approval.

12) The Respondent made post-eligibility calculations in conjunction with its approval of the Appellant's May 2025 LTC Medicaid application.

13) The Respondent did not provide notification letters regarding the Appellant's post-eligibility calculations – which include factors affected by the Appellant's non-reimbursable medical expenses, or "remedial expenses."

14) The Appellant requested a hearing to appeal an unfavorable determination of the Appellant's "remedial" expenses by the Respondent.

APPLICABLE POLICY

West Virginia Income Maintenance Manual § 24.1, provides, in part (emphasis added):

> This chapter describes the Department of Human Services' (DOHS) policies and procedures related to eligibility for long term care (LTC). LTC includes both institutional care and non-institutional Home and Community-Based Services (HCBS).
>
> • Institutional care includes nursing facilities (NF) and intermediate care facilities for individuals with intellectual disabilities (ICF/IID).
>
> • West Virginia's HCBS include four programs. These are for people who would otherwise need institutional level of care, but have chosen to receive care in the community.
>
> West Virginia has been granted waivers by the Centers for Medicare and Medicaid Services (CMS) to provide HCBS to several target populations:
>
> o Aged or disabled people under the Aged and Disabled Waiver (ADW)

o Intellectually or developmentally disabled individuals under the Intellectual Disabilities and Developmental Disabilities (I/DD) Waiver

o Individuals with traumatic brain injury under the Traumatic Brain Injury (TBI) Waiver

Additionally, West Virginia has opted to implement the Children with Disabilities Community Services Program (CDCSP) eligibility category, which allows for children who would otherwise need an institutional level of care to receive services in the community.

This chapter covers policies relating to individuals in two different situations:

• Clients who are already enrolled in or eligible for Medicaid who have a new need for LTC.

• Applicants who were not eligible for Medicaid at the time of application, but who may have become eligible because of their need for LTC.

All LTC programs require a determination of **medical eligibility, as well as a determination of financial eligibility** conducted by the Worker.

This chapter also sets out policies and procedures for **determining if clients found eligible for institutional care must contribute to their cost of care**…

West Virginia Income Maintenance Manual, § 24.4.1.C.10, provides, in part:

➢ Medicaid Eligibility

Medicaid eligibility begins on the first day of the month in which eligibility is established. Eligibility may be backdated up to three months prior to the month of application, when all eligibility requirements were met, and the client has medical expenses for which he seeks payment.

➢ Payment for Nursing Facility Services

Payment for nursing facility services begins on the earliest date the three conditions described below are met simultaneously. Payment for nursing facility services may be backdated up to three months prior to the month of application when all the conditions described below are met for that period.

• The client is eligible for Medicaid; and

• The client resides in a Medicaid-certified nursing facility; and

• There is a valid pre-admission screening (PAS) or, for backdating purposes only, physician's progress notes or orders in the client's medical records. Section 24.12 contains information about the PAS and details specific situations in which the progress notes or orders are used…

West Virginia Income Maintenance Manual, § 24.7.3, provides:

> The post-eligibility process does not apply to the MAGI Medicaid coverage groups – Adult Group, Parents/Caretaker Relatives, Pregnant Women, Children Under Age 19, or certain QMB clients. MAGI Medicaid coverage groups and QMB clients for whom Medicare pays a full month do not contribute to the cost of their nursing facility care.
>
> Income sources that are excluded for the coverage group under which eligibility is determined are also excluded in the post-eligibility process for nursing facility services. See Section 4.3 for excluded sources for the appropriate coverage group.
>
> In determining the client's contribution toward his cost of nursing facility care, the Worker must apply only the income deductions listed below. This is the post-eligibility process. The remainder, after all allowable deductions, is the resource amount, which is at least part of the amount the client must contribute toward his cost of care.
>
> The client's spenddown amount, if any, as determined above, is added to the resource amount to determine the client's total contribution toward his nursing care, except when there is a community spouse. In cases with a community spouse, the spenddown is not added to the computed resource amount. The spenddown is used only to compare to the nursing facility's Medicaid cost of care to determine eligibility. See Section 24.7.6.

West Virginia Income Maintenance Manual, § 24.7.3.A, provides:

> Only the items in the following sections may be deducted from the client's gross income in the post-eligibility process.

West Virginia Income Maintenance Manual, § 24.7.3.A.5, provides, in part (emphasis added):

> Certain non-reimbursable medical expenses for the eligible client only may be deducted in the post-eligibility process. These expenses are sometimes referred to as "remedial expenses."
>
> Non-reimbursable means the expense will not be or has not been paid to the provider or reimbursed to the client by any third-party payer, such as, but not limited to, Medicare, Medicaid, private insurance or another individual.
>
> …
>
> Time Limits and Verification Requirements for Expenses
>
> ▪ Applicants

A non-reimbursable medical expense may be permitted only for **services provided in the month of application and the three months prior to the month of application**.

…

▪ Clients Residing in a Nursing Facility

The request for consideration of a non-reimbursable medical expense must be **submitted within one year of the date of service(s)**.

Documentation must consist of the following:

• An order and statement of the medical necessity from a prescribing physician, dentist, podiatrist or other practitioner with prescribing authority under West Virginia law; and

• **An itemization of the services provided. When the request to deduct non-reimbursable medical expenses originates from a nursing facility or is presented by the client as a bill from a nursing facility, a detailed itemization of the services must be provided. The itemization must include:**

o The date of the service or expense;

o The specific medical service;

o **The reason no payment was received by the facility**; and

o The amount of the expense.

…

Expenses which Cannot Be Used

The following expenses cannot be used as a deduction for non-reimbursable medical expenses:

…

• **Nursing facility charges when the reason for Medicaid ineligibility is the facility's failure to obtain an approved preadmission screening (PAS)**…

West Virginia Income Maintenance Manual, § 24.12.2.A, provides:

Before payment for nursing facility services can be made, medical necessity must be established for all clients. The PAS is the tool used for this purpose. The PAS is signed by a physician and then evaluated by a medical professional working with the State's contracted level of care evaluator. The PAS is valid for 60 days from the date the physician signs the form, which is the only date used for establishment of medical necessity. The 60-day validity period applies, regardless of the reason for the completion. See below for situations when a PAS is not completed and payment for nursing facility care is requested for a prior period.

When the PAS indicates the client is not in need of nursing facility care, the application for Medicaid, unless withdrawn, is processed for any other coverage group for which the person qualifies, and all client notification procedures apply.

When the client no longer has medical necessity for long term care services, the nursing facility must notify the Worker.

There is no requirement that the name of the facility in which the client resides appear on the PAS.

West Virginia Income Maintenance Manual, § 24.12.2.A, provides (emphasis added):

For Medicaid to pay for nursing facility services, the PAS must be completed when:

• The client enters a Medicaid-certified nursing facility.

• The client transfers from one facility to another, even when the client moves from one facility to another governed by the same corporation, and even when 60 days has not passed since the completion of the PAS for the first facility.

• The client is admitted to an acute care facility and returns to the same nursing facility after 60 days.

• The client's condition changes to the extent that he no longer requires nursing facility services.

• Nursing facility care is approved for a limited time, a new PAS must be submitted by the facility before the end of the approved period.

• **A private-pay patient applies for Medicaid, unless an approved PAS was completed within 60 days prior to the application.**

This applies even if a PAS certifying medical need was completed at the time of admission to an approved facility. This also applies if a PAS was completed any other time before 60 days prior to the application. The new PAS certifies current need for nursing facility services.

A previously approved PAS may be used for backdated eligibility and payment for nursing facility services, so long as the client has remained in the same facility since completion of the previously approved form.

DISCUSSION

The Appellant requested a hearing to appeal the Respondent's determination of post-eligibility calculations related to the Appellant's approval for LTC Medicaid. These calculations included a "denial" of a "remedial" by the Respondent, or disallowance of non-reimbursable medical expenses (NRME) requested by the Appellant. The Respondent must show, by a preponderance of the evidence, that it corrected excluded NRME requested by the Appellant.

The Appellant applied for LTC Medicaid in September 2024 and was denied by the Respondent. The Appellant appealed this action, the Board of Review held a hearing, and a decision was issued to the Appellant affirming the Respondent's denial. The Appellant was provided appeal recourse rights in the May 2025 Board of Review decision (25-BOR-[redacted], Exhibit D-1), and the matter is not being redetermined in a second hearing before the Board of Review.

Policy requires three conditions for payment of nursing facility services: Medicaid eligibility, nursing facility residence, and a valid PAS. Regardless of residence or PAS validity, the previous hearing settled the matter of Medicaid eligibility: the Appellant was not eligible in September 2024. Neither party submitted any additional LTC Medicaid applications within 60 days of the September 2024 PAS.

The Appellant reapplied for LTC Medicaid on May 30, 2025. This application listed May 30, 2025, as the Appellant's admission date at the nursing facility. The Appellant submitted a PAS dated May 27, 2025. The Respondent approved this LTC Medicaid application, and the Appellant requested the consideration of NRME or "remedial" expenses in conjunction with the post-eligibility calculations. The Respondent denied this request, and although the parties agreed that the request and denial were accomplished by email, this is unclear. The Respondent prepared an evidence packet that included printouts of four email chains – one was not admitted because it listed details of an unrelated case, two were partly unreliable because not all the pages were included, and the remaining email chain did not clearly show proper notification by the Respondent. It is believed that the Respondent communicated this negative action indirectly through notices related to its post-eligibility calculations, although they failed to provide any such notice. The noticing issue notwithstanding, the three policy requirements for nursing facility payment were met on May 30, 2025. The Appellant was approved from the same date. The Respondent included a document without foundation or explanation that appears to be an itemized list (Exhibit D-2) of NRME. This list does not meet policy requirements or list expenses after the Appellant's May 30, 2025, approval date. Policy explicitly states that disallowed NRME include "…nursing facility charges when the reason for Medicaid ineligibility is the facility's failure to obtain an approved preadmission screening (PAS)."

The Appellant was ultimately approved for LTC Medicaid in conjunction with her May 2025 application, but the payment for nursing facility services cannot be made before the date when all three conditions were met. The Appellant was denied LTC Medicaid – and this denial was affirmed in a prior hearing – for the facility's failure to obtain an approved PAS. Policy does not allow consideration of NRME in this exact situation. The Respondent's decision to deny the remedial request – or factor requested expenses into the Appellant's post-eligibility calculations – is affirmed.

CONCLUSIONS OF LAW

1) The Appellant was established ineligible for LTC Medicaid in September 2024, and this denial was affirmed in a previous Board of Review decision.

2) The Appellant's September 2024 PAS cannot solely establish a period of payment for nursing facility services because policy requires two other conditions: nursing facility residence, and LTC Medicaid eligibility.

3) Because the Appellant met the three conditions for payment of LTC Medicaid nursing facility services on May 30, 2025, a request for consideration of non-reimbursable medical expenses (NRME) incurred before that date cannot be approved.

4) Because the Appellant's request for NRME was in conjunction with a failure by the Appellant's nursing facility to provide a valid PAS in a timely manner, policy does not allow these expenses to be considered.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's denial of consideration of the Appellant's "remedial" or non-reimbursable medical expenses for Long-Term Care Medicaid.

ENTERED this _____ day of November 2025.

_____

Todd Thornton
State Hearing Officer