November 4, 2025

[redacted]

RE: [redacted] v. WV DoHS/BMS
ACTION NO.: 25-BOR-2953

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 (DoHS). 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,

Tara B. Thompson, MLS
Certified State Hearing Officer
Member, State Board of Review

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

cc: Terry McGee, II – 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-2953**

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 15, 2025.

The matter before the Hearing Officer arises from the Respondent's decision on September 12, 2025, to deny the Appellant's eligibility for Medicaid Long-Term Care (LTC) admission.

At the hearing, the Respondent appeared by Terry McGee, II, Bureau for Medical Services (BMS). Appearing as a witness for the Respondent was Melissa Grega, RN, Acentra. The Appellant appeared and was self-represented. Appearing as witnesses for the Appellant were [redacted] Facility Social Worker; [redacted] Facility Social Worker; and [redacted] Facility Business Office Manager. All witnesses were placed under oath and the following documents were admitted into evidence.

Department's Exhibits:
D-1 Exhibit summary
Notice, dated September 12, 2025
D-2 Bureau for Medical Services (BMS) Chapter 514 policy excerpts
D-3 Pre-Admission Screening (PAS), submitted on September 11, 2025
D-4 Facility records

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] (hereafter the Facility), a Long-Term Care (LTC) facility.

2) On September 12, 2025, the Respondent issued a notice advising the Appellant his request for LTC admission was denied because the Pre-Admission Screening (PAS) failed to identify at least five (5) areas of care needs that met severity criteria (Exhibit D-1).

3) The PAS identified deficiencies that met the severity criteria in *Bathing* and *Walking* (Exhibit D-1 and D-3).

4) At the time of the PAS, the Appellant did not have a decubitus (Exhibit D-3).

5) At the time of the PAS, the Appellant was able to vacate independently in the event of an emergency (Exhibit D-3).

6) At the time of the PAS, the Appellant was assessed as Level 1 – Self/Prompting, in the areas of *eating, dressing,* and *grooming* (Exhibit D-3).

7) At the time of the PAS, the Appellant was assessed as Level 1- Continent, in the areas of bladder and bowel *continence* (Exhibit D-3).

8) At the time of the PAS, the Appellant was oriented (Exhibit D-3).

9) At the time of the PAS, the Appellant was assessed as Level 1- Independent, in the area of *transferring* (Exhibit D-3).

10) At the time of the PAS the Appellant was assessed as Level 1- No Wheelchair, in the area of *wheeling* (Exhibit D-3).

11) At the time of the PAS, the Appellant did not have skilled needs in suctioning, tracheostomy, ventilator, parenteral fluids, sterile dressings, or irrigations (Exhibit D-3).

12) At the time of the PAS, the Appellant had an active order: "Resident MAY NOT administer own meds" (Exhibit D-4).

13) At the time of the PAS, the Appellant was assessed as capable of administering his own medications (Exhibit D-3).

14) The physician recommendations indicated that the Appellant's prognosis was stable and his rehabilitative potential was good (Exhibit D-3).

15) The physician recommendations indicated the Appellant was recommended for nursing facility placement only and that he would not be able to eventually return home or be discharged based on the present medical findings (Exhibit D-3).

16) The physician recommendations did not indicate a recommended length of stay (Exhibit D-3).

APPLICABLE POLICY

Bureau for Medical Services (BMS) Manual § 514.5.3 ***Medical Eligibility Regarding Pre-Admission Screening*** provides that to medically qualify for the nursing facility Medicaid benefit, an individual must need direct nursing care 24 hours a day, seven days a week. The BMS has designated a tool, known as the PAS form, to be utilized for physician certification of the medical needs of individuals applying for Medicaid benefits. The PAS 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 …."

To qualify for nursing facility Medicaid benefit, an individual must have a minimum of five deficits identified on the PAS. 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 mentally or physically unable to vacate a building. Independently and 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…)
    - 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 person assist in the home)
    - Walking: Level 3 or higher (one person assistance in the home)
    - Wheeling: Level 3 or higher
- #27: Individual has skilled needs in one of these areas: suctioning, tracheostomy, ventilator, parenteral fluids, sterile dressings, or irrigations
- #28: Individual is not capable of administering his/her own medications

Code of Federal Regulations 42 CFR 483.20 ***Resident assessment*** provides that the facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. …

(g) *Accuracy of assessments*. The assessment must accurately reflect the residents' status.

DISCUSSION

On September 12, 2025, the Respondent denied the Appellant's medical eligibility for Medicaid Long-Term Care (LTC) benefits because the PAS did not identify the presence of severe deficits in five functioning areas. According to the Respondent's notice, severe deficits were identified in the areas of *Bathing* and *Walking*. During the hearing, the Appellant argued that he still required rehabilitative treatment provided by the Facility and requested that he be supplied with leg prosthetics before being discharged.

Dispute about medical services being provided to the Appellant upon discharge from the Facility cannot be addressed on the instant appeal. The Board of Review can only decide whether the Respondent correctly denied the Appellant's eligibility for Medicaid LTC based on reliable information provided on the PAS. To verify that the Appellant was correctly denied eligibility, the preponderance of evidence had to demonstrate that a reliable PAS failed to identify the presence of severe functioning deficits in five areas.

Federal regulations require assessments of facility residents to accurately reflect the resident's status. The BMS Manual provides that the assessment tool must be completed, signed, and dated by a physician certifying that the patient's medical and related needs are as indicated within the assessment.

Although the PAS assessment marked that the Appellant could administer his own medications, at the time of the PAS, the Appellant had an active order that he may not administer his own medications.

The physician's recommendations for nursing facility placement only and indication that the Appellant would not be able to return home or be discharged were discrepant with the physician's assessment of the Appellant's functioning deficits. During the hearing, the Appellant's witness testified that the physician recommendations conflicted with staff discussions regarding the Appellant's prognosis and ability to be discharged.

According to the preponderance of evidence, the PAS reflected discrepancies between the assessment and physician orders for medication administration and nursing placement recommendations. As multiple inconsistencies exist between the PAS, physician orders, and testimony during the hearing, the PAS cannot be relied upon when determining the Appellant's eligibility for Medicaid LTC benefits.

According to the evidence, the Respondent incorrectly denied the Appellant's Medicaid LTC eligibility based on an unreliable PAS. The matter must be remanded for a new PAS and new decision regarding the Appellant's Medicaid LTC benefit eligibility.

CONCLUSIONS OF LAW

1) To be eligible for Medicaid Long-Term Care, a reliable PAS had to demonstrate that the Appellant had five areas of care deficits that met severity criteria when the PAS was completed on September 11, 2025.

2) The preponderance of evidence revealed that the PAS reflected conflicting assessment and physician recommendations and did not agree with the Appellant's active medication administration orders.

3) Because the PAS reflected conflicting information, the reliability of the PAS could not be established.

4) As the Respondent's decision to deny the Appellant's Medicaid LTC eligibility was based on an unreliable PAS, the Respondent's decision to deny his eligibility cannot be affirmed and the matter must be remanded for a new assessment.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's decision to deny the Appellant's Medicaid LTC eligibility based on the PAS completed on September 11, 2025. The matter is **REMANDED** for a new PAS and decision regarding the Appellant's eligibility. The Appellant retains the right to appeal anew any subsequent decision made by the Respondent.

ENTERED this 4th day of November 2025.

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Tara B. Thompson, MLS
Certified State Hearing Officer