December 10, 2025

[redacted]

RE: [redacted] v. DoHS/BUREAU FOR MEDICAL SERVICES
ACTION NO.: 25-BOR-3251

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-3251**

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 December 9, 2025.

The matter before the Hearing Officer arises from the August 22, 2025, decision by the Respondent to deny medical eligibility for Long Term Care Medicaid benefits.

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

Department's Exhibits:

D-1 Notice of Denial dated August 22, 2025
D-2 Bureau for Medical Services/Acentra Health Policy §514.5
D-3 Pre-Admission Screening dated August 20, 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 applied for Long Term Care (LTC) Medicaid benefits.

2) A Pre-Admission Screening (PAS) was completed for the Appellant on August 20, 2025, to determine medical eligibility for LTC Medicaid (Exhibit D-3).

3) The Appellant was awarded deficits in *bathing*, *dressing*, *walking*, and *wheeling* on the August 2025 PAS (Exhibit D-3).

4) The Appellant is prescribed Vesicare to treat an overactive bladder (Exhibit D-4).

5) The Respondent sent a notice to the Appellant on August 20, 2025, advising that her application for LTC services had been denied as the documentation did not reflect at least five deficits at the required level (Exhibit D-2).

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 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 person 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 LTC services funded 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 to be medically eligible for LTC Medicaid.

The Appellant applied for Long Term Care services and a PAS was completed to determine medical eligibility for the program. The Appellant received four deficits on the August 2025 PAS in the areas of *bathing, dressing, walking,* and *wheeling*. The Appellant contested not receiving a deficit for *bladder continence*.

The Appellant was assessed as a Level 2 for bladder continence – occasionally incontinent. The Appellant testified that she wears incontinence briefs and estimated that she changes her briefs five times a day due to bladder accidents. The Appellant stated that she is unable to get up at night due to mobility issues and often has accidents.

The Appellant was assessed as requiring two-person assistance to walk and requiring situational assistance with her wheelchair. The Appellant takes a medication to treat an overactive bladder. Based on the Appellant's mobility issues and diagnosis of an overactive bladder, the Appellant's contention that she is incontinent of bladder is supported by the evidence.

Based on the credible testimony of the Appellant and supporting documentation, the Appellant should have been assessed as a Level 3 – incontinent – for *bladder continence*. Whereas the Appellant has five functional deficits, she meets the medical eligibility criteria for LTC Medicaid.

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 awarded four deficits on the August 2025 Pre-Admission Screening.

3) The evidence established an additional deficit for the Appellant in *bladder continence.*

4) The Appellant meets the medical eligibility criteria for Long Term Care services funded by Medicaid.

DECISION

It is the decision of the State Hearing Officer to **reverse** the decision of the Respondent to deny medical eligibility for Long Term Care Medicaid.

ENTERED this 10th day of December 2025.

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Kristi Logan
Certified State Hearing Officer