January 22, 2026

[redacted]

RE: [redacted] v. DoHS/BMS
ACTION NO.: 26-BOR-1012

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: 26-BOR-1012**

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 January 21, 2026.

The matter before the Hearing Officer arises from the December 16, 2025, decision by the Respondent to terminate Long Term Care services for the Appellant.

At the hearing, the Respondent appeared by Terry McGee, Bureau for Medical Services. Appearing as a witness for the Respondent was Melissa Grega, nurse reviewer with Acentra Health. The Appellant appeared by her daughter, [redacted] Appearing as a witness for the Appellant was [redacted] The witnesses were placed under oath, and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Notice of Denial dated December 16, 2025
D-2 Bureau for Medical Services Provider Manual §514.5
D-3 Pre-Admission Screening dated December 15, 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 is a resident of [redacted] Medical Center nursing facility.

2) A Pre-Admission Screening (PAS) was completed for the Appellant on December 15, 2025, to determine continued medical eligibility for LTC services funded by Medicaid (Exhibit D-3).

3) The Appellant was awarded deficits in *bathing*, and *medication administration* on the December 2025 PAS (Exhibit D-3).

4) The Appellant has diagnoses of dementia, hearing loss, and Meniere's disease (Exhibit D-3).

5) The Respondent sent a notice to the Appellant on December 16, 2025, advising that the documentation submitted did not reflect at least five deficits at the required level (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 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 was reevaluated for LTC Medicaid, and a PAS was completed to determine continued medical eligibility for the program. The Appellant received two deficits on the December 2025 PAS in the areas of *bathing* and *medication administration*. The Appellant disputed not receiving deficits in *vacating in an emergency, dressing, grooming, bladder continence, hearing, communication* and *professional/technical care needs.*

Vacating in an Emergency

The Appellant was assessed as requiring supervision to *vacate a building in an emergency*. The Appellant's daughter, [redacted], testified that the Appellant is deaf and would be unable to hear a fire alarm or otherwise be alerted for the need to vacate a building in an emergency. Ms. [redacted] stated that her mother has dementia, is often disoriented and would be unable to vacate without assistance. Based on the Appellant's diagnoses of dementia and hearing loss, the Appellant would require assistance to *vacate in an emergency*, and a deficit will be awarded in this area.

Dressing

The Appellant was assessed as a level 1 – self/prompting – in *dressing*. Ms. [redacted] testified that her mother has Meniere's disease, a condition which affects her balance, and requires assistance with dressing. Ms. [redacted] stated her mother needs help standing up and assistance to remain balanced to pull on her pants. Based on the testimony provided, the Appellant requires assistance with *dressing* and a deficit will be awarded in this area.

Grooming

The Appellant was assessed as a level 1 – self/prompting – in *grooming*. Ms. [redacted] stated that due to the Meniere's disease, the Appellant must keep her ears dry. Ms. [redacted] stated that twice a week the nursing facility staff washes her hair in a shampoo bowl while she wears ear plugs. Based on the testimony provided, the Appellant requires assistance in *grooming* and a deficit will be awarded in this area.

Bladder Continence

The Appellant was assessed as a level 2 – occasional incontinence – in *bladder continence*. [redacted], witness for the Appellant, testified that the Appellant is totally incontinent of the bladder. Ms. [redacted] contended that the Appellant wears incontinent briefs and has bladder accidents every night. Based on the testimony provided, the Appellant's bladder accidents occur more than three times a week and will be awarded a deficit in *bladder continence*.

Hearing and Communication

The Appellant was assessed as level 2 – impaired/correctable – in *hearing* and level 1 – not impaired – in *communication*. Although Ms. [redacted] contended the Appellant's hearing loss is not correctable and affects her ability to communicate, per policy, hearing and communication are areas in which a deficit can be given.

Professional/Technical Care Needs

To receive a deficit under *professional/technical care needs*, an individual must have a skilled need for suctioning, tracheostomy, ventilator, parenteral fluids, sterile dressings, or irrigations. The Appellant receives speech therapy services, which does not constitute a deficit.

Based on the credible testimony and documentation provided, the Appellant was found to have deficits in *vacating a building in an emergency, dressing, grooming,* and *bladder continence*. Whereas the Appellant has six deficits, meeting the minimum requirement of five deficits, she continues to meet 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 two deficits on the December 2025 Pre-Admission Screening.

3) The evidence established additional deficits for the Appellant in *vacating a building in an emergency, dressing, grooming,* and *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 terminate the Appellant's Long Term Care Medicaid.

ENTERED this 22nd day of January 2026.

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Kristi Logan
Certified State Hearing Officer