



August 20, 2026

RE: [REDACTED] v. WV DoHS/BMS
ACTION NO.: 26-BOR-2278

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,

Amy Hayes
State Hearing Officer
Member, State Board of Review

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

cc: Terry McGee, Department Representative
Kesha Walton

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

[REDACTED]
Appellant,

v.

Action Number: 26-BOR-2278

**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 July 30, 2026, on an appeal filed with the Board of Review on July 9, 2026.

The matter before the Hearing Officer arises from the May 4, 2026 decision by the Respondent to deny the Appellant's request for Long-Term Care (Nursing Facility) Medicaid because he was found medically ineligible.

At the hearing, the Respondent appeared by Terry McGee, Department Representative. Appearing as a witness for the Respondent was Melissa Grega, Nurse Reviewer with Acentra Health. The Appellant was not present and was represented by his wife [REDACTED]. Appearing as a witness for the Appellant was [REDACTED]. Also appearing as a witness was [REDACTED], Executive Director of [REDACTED]. All witnesses were placed under oath and the following documents were admitted into evidence.

Department's Exhibits:

- D-1 Notice of Denial For Long-Term Care (Nursing Facility) from Acentra Health to [REDACTED] dated May 4, 2026
- D-2 Chapter 514 Nursing Facility Services Policy
- D-3 Pre-Admission Screening (PAS) form completed March 13, 2026, submitted May 4, 2026
- D-4 Medication List of Active Orders as of May 4, 2026

Appellant's Exhibits:

- A-1 Medical Records of [REDACTED] dated October 19, 2022, through December 2, 2025
A-2 Medical Record of [REDACTED] dated December 27, 2024

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) On May 7, 2024, the Appellant was admitted to the emergency department of [REDACTED] General Hospital because he fell and hit his head. The admission exam states that the Appellant had a “recent MRI and FDG PET scan that was remarkable for findings consistent [frontotemporal dementia] FTD with parkinsonian symptoms.” (Exhibit A-1)
- 2) On May 13, 2024, a Pre-Admission Screening (PAS) was completed with the Appellant by Dr. [REDACTED]. On the PAS, the doctor determined that the Appellant had seven (7) deficits. (Exhibit A-1)
- 3) On the May 13, 2024 PAS, the doctor listed diagnoses of Fronto-temporal dementia, at risk for falls, gait instability, seizures, PTSD, and hyperlipidemia. Nursing facility placement was recommended. (Exhibit A-1)
- 4) The Appellant was admitted to [REDACTED] Health Care Center, which is a Medicaid certified nursing facility, on January 24, 2025. (Exhibit D-3)
- 5) Medical eligibility for the Long-Term Care (Nursing Facility) Medicaid program requires deficits in at least five (5) of 13 critical areas. (Exhibit D-2)
- 6) The Appellant was diagnosed with a new condition around March of 2026, and [REDACTED] Health Care Center was required to determine whether the Appellant continued to be medically eligible for long-term care nursing facility services.
- 7) On March 13, 2026, a new PAS was completed with the Appellant by Dr. C [REDACTED] at [REDACTED] Health Care Center. (Exhibit D-3)
- 8) At the time of the PAS, the Appellant was not mentally able to vacate a building in an emergency. (Exhibit D-3)
- 9) At the time of the PAS, the Appellant required Level 2 “Physical Assistance” in grooming. (Exhibit D-3)
- 10) At the time of the PAS, the Appellant could walk supervised or with an assistive device, which was Level 2 functional ability in walking. (Exhibit D-3)

- 11) At the time of the PAS, the Appellant required physical assistance in dressing.
- 12) At the time of the PAS, the Appellant was oriented. (Exhibit D-3)
- 13) At the time of the PAS, the Appellant was capable of administering his own medications with prompting supervision. (Exhibit D-3)
- 14) At the time of the PAS, the Appellant could bathe by himself or with prompting, did not require assistance with eating, was able to transfer independently, did not meet deficits in decubitus, continence of bowel, use of a wheelchair, and did not have any professional or technical needs in the areas of suctioning, tracheostomy, ventilator, parenteral fluids, sterile dressings, or irrigations (Exhibit D-3).
- 15) On May 4, 2026, the PAS was submitted to Acentra, and the Respondent issued a notice to the Appellant advising his request for Long-Term Care admission had been denied because the Pre-Admission Screening (PAS) form did not identify five (5) deficit areas that met severity criteria (Exhibit D-1).

APPLICABLE POLICY

Bureau of Medical Services (BMS) Manual, Chapter 514, § 514.3, describes Standards for Nursing Facilities, in pertinent part:

514.3 Standards For Nursing Facilities

All providers participating as a nursing facility in the Title XIX, Medicaid program must comply with federal standards as published in the Code of Federal Regulations and as later amended; as well as state laws and Program Regulations governing the state.

BMS Manual, Chapter 514, § 514.5, Member Eligibility Requirements, describes Application Procedures, in pertinent part:

514.5 Member Eligibility Requirements

514.5.1 Application Procedures

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.

BMS Manual § 514.5.2 *Pre-Admission Screening (PAS)* provides in relevant sections: 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.

BMS Manual § 514.5.3 *Medical Eligibility Regarding the PAS* provides in relevant sections: 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 BMS 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 a BMS/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
- #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 BMS 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.

Bureau for Medical Services (BMS) Manual § 514.5.4 Medical Necessity (Level I) provides in relevant sections: All individuals admitted or requesting admission to a Medicaid certified nursing facility must be screened for the possible presence of a mental illness, and/or an Intellectual/Developmental Disability (I/DD). This review is identified as the Level I (PAS) evaluation. Any individual identified with the possible presence of mental health issues must be further evaluated in the Level II PASRR.

The Code of Federal Regulations §§ 483.100 through 483.138 describe the State's responsibility for preadmission screening and annual resident review (PASARR), in pertinent part:

§ 483.100 Basis.

The requirements of §§ 483.100 through 483.138 governing the State's responsibility for preadmission screening and annual resident review (PASARR) of individuals with mental illness and mental retardation are based on section 1919(e)(7) of the Act.

§ 483.102 Applicability and definitions.

(a) This subpart applies to the screening or reviewing of all individuals with mental illness or mental retardation who apply to or reside in Medicaid certified NFs regardless of the source of payment for the NF services, and regardless of the individual's or resident's known diagnoses.

(b) Definitions. As used in this subpart—

(1) An individual is considered to have a serious mental illness (MI) if the individual meets the following requirements on diagnosis, level of impairment and duration of illness:

(i) Diagnosis. The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised in 1987. Incorporation of the 1987 edition of the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51 that govern the use of incorporation by reference.[1]

This mental disorder is—

(A) A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability; but

(B) Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined in paragraph (b)(1)(i)(A) of this section.

(ii) Level of impairment. The disorder results in functional limitations in major life activities within the past 3 to 6 months that would be appropriate for the individual's developmental stage. An individual typically has at least one of the following characteristics on a continuing or intermittent basis:

(A) Interpersonal functioning. The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible

history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation;

(B) Concentration, persistence, and pace. The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks; and

(C) Adaptation to change. The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

(iii) Recent treatment. The treatment history indicates that the individual has experienced at least one of the following:

(A) Psychiatric treatment more intensive than outpatient care more than once in the past 2 years (e.g., partial hospitalization or inpatient hospitalization); or

(B) Within the last 2 years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

(2) An individual is considered to have dementia if he or she has a primary diagnosis of dementia, as described in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised in 1987, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined in paragraph (b)(1)(i)(A) of this section.

(3) An individual is considered to have intellectual disability (IID) if he or she has—

(i) A level of retardation (mild, moderate, severe or profound) described in the American Association on Intellectual Disability's Manual on Classification in Intellectual Disability (1983). Incorporation by reference of the 1983 edition of the American Association on Intellectual Disability's Manual on Classification in Intellectual Disability was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51 that govern the use of incorporations by reference;^[2] or

(ii) A related condition as defined by § 435.1010 of this chapter.

DISCUSSION

Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that Medicaid-certified nursing facilities evaluate all applicants for serious mental illness and intellectual disability, offer all applicants the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings), and provide all applicants the services they need in those settings.

The medical eligibility determination is based on a physician's assessment of the medical and physical needs of the individual. The Respondent has designated a tool known as the Pre-Admission Screening (PAS) to be utilized for physician certification of the medical needs of individuals. To qualify medically for Long-Term Care nursing facility services, an individual must have a minimum of five (5) deficits identified on the PAS.

A previous PAS, completed with the Appellant on May 13, 2024, reflected that the Appellant was medically eligible for nursing facility services at that time because it identified the presence of deficits in seven (7) areas. On the previous PAS, the doctor listed diagnoses of "Fronto-temporal dementia, at risk for falls, gait instability, at risk for falls, seizures, PTSD, and hyperlipidemia." Nursing facility placement was recommended for less than 3 months and the rehabilitative potential was listed as "Good."

The Appellant was admitted to [REDACTED] Health Care Facility, which is a Medicaid-certified nursing facility, on January 24, 2025. The Appellant has been living there since then. A new PAS was completed on March 13, 2026, because the Appellant had a new diagnosis which meant he had a change in his condition. The PAS was signed by Dr. [REDACTED] and submitted to the Respondent on May 4, 2026. [REDACTED] Executive Director of [REDACTED] testified that Dr. [REDACTED] is currently the Appellant's primary care physician. The PAS reflected two (2) deficits for the Appellant, in the areas of grooming and vacating. The Respondent denied the Appellant's medical eligibility for Long-Term Care Medicaid benefits because the PAS did not identify the presence of deficits in five (5) areas.

The Appellant's wife, [REDACTED] represented the Appellant during the hearing. [REDACTED] cared for the Appellant in their home until he was admitted to the nursing facility. Mrs. [REDACTED] sister, [REDACTED] gave testimony, and spoke on behalf of [REDACTED] during portions of the hearing. [REDACTED] knew the Appellant before the onset of his symptoms and is very familiar with the Appellant's condition as it progressed. However, the Appellant has been at the nursing facility for over a year, and [REDACTED] testimony did not account for any progress and improvements the Appellant demonstrated at the time of his current PAS.

The testimony and evidence showed that the Appellant was diagnosed with frontotemporal dementia in May of 2024. The Appellant had fallen several times in the previous years which resulted in multiple emergency room treatments with varying injuries. On May 7, 2024, the Appellant was admitted to the [REDACTED] emergency department because he fell and hit his head. The admission exam states that the Appellant had a "recent MRI and FDG PET scan that was remarkable for findings consistent [frontotemporal dementia] FTD with parkinsonian symptoms."

[REDACTED] and [REDACTED] dispute the results and validity of the May 4, 2026 PAS. [REDACTED] testified as to the cognitive decline of the Appellant. She contends that the Appellant's medical history and physical condition warrant long-term care treatment. [REDACTED] testified that the Appellant has a progressive neurodegenerative disease that significantly impairs judgment, impulse control, decision making, behavioral functioning, and executive functioning. This disease will not improve. However, the PAS is an instrument that measures the medical need for nursing

facility services based on evaluation of identified physical deficits, not cognition or behavioral deficits. [REDACTED] also contends that the Appellant is not oriented, requires physical assistance in dressing, cannot administer his own medication, and requires physical assistance in walking.

Orientation

The Appellant's orientation was assessed as a Level 1, oriented. [REDACTED] and [REDACTED] testified that the Appellant has cognitive decline due to his frontotemporal dementia, has aggressive behaviors, and poses a danger to his family. To receive a deficit in orientation, an individual must be totally disoriented or comatose. The Respondent's witness, Melissa Grega, testified that a person is totally disoriented if they do not know where they are, or if they are not oriented to time. [REDACTED] did not show that the Appellant did not know where he was or was not oriented to time, or that he was comatose. Therefore, a deficit cannot be awarded in this area.

Dressing

The Appellant was assessed as a Level 1, self/prompting, in dressing. [REDACTED] testified that the Appellant requires assistance in dressing. [REDACTED] testified that the Appellant requires physical assistance with dressing because his shoulders have spasms. To receive a deficit in dressing, a Level 2 means that the person needs hands-on assistance to dress, such as being unable to button or zip clothing or unable to put on their socks and shoes. A Level 3 means that the person cannot participate at all in dressing. The evidence showed that the Appellant requires physical assistance in dressing, and should have received a Level 2 in this area.

Medication Administration

The Appellant was assessed as requiring prompting/supervision with medication administration. [REDACTED] testified that the Appellant's hand shakes too much to be able to take his medication without supervision because of his frontotemporal dementia with Parkinsonian symptoms. To receive a deficit in medication administration, an individual must be physically unable to administer medications, whether orally or by injection. The testimony provided did not support that the Appellant is physically unable to place medications in his own mouth. The evidence showed that the Appellant can take his own medication with supervision.

Walking

The Appellant was assessed as a Level 2, supervised/assistive device, in walking. [REDACTED] testified that the Appellant uses a walker, falls frequently, and was diagnosed as a fall-risk. Evidence showed that the Appellant has been diagnosed with frontotemporal dementia (FTD) with parkinsonian symptoms, seizure disorder, and gait instability. To receive a Level 2 deficit in walking, an individual must use a walker or assistive device or need supervision, but does not need hands on assistance. A Level 3 deficit in walking means the person needs someone to physically hold on to them to help them balance. A Level 4 deficit means the person needs two-person assistance to walk or cannot walk at all.

Being diagnosed as a fall-risk is not the same as needing one person physical or hands-on assistance to walk. The evidence showed that the Appellant can walk without one person physical or hands-on assistance, because he can walk with an assistive device. The Appellant's functional ability in walking was correctly assessed at a Level 2.

Mental Illness/PASRR Determination “Level II”

██████ testified that the Appellant’s frontotemporal dementia causes behavior problems, including aggression, which necessitate nursing facility care. The PAS form indicated that the Appellant has a Current Diagnosis of Seizure Disorder, Bipolar Disorder in Full remission, Major Depression, Post Traumatic Stress Disorder, Mood Disorder, and Frontotemporal neurocognitive disorder. Despite this, the physician indicated an answer of “No” to #31 on the PAS (Has an individual ever received services from an agency serving persons with mental retardation/developmental disability and/or mental illness?)

On questions #40 of the PAS, the physician indicated that the Appellant has “Major Mental Illness or suspected MI” of Major Depressive Disorder and Panic Disorder. Any individual identified with the possible presence of mental health issues must be further evaluated in the Level II PASRR. The Respondent did not offer any testimony regarding the contradiction between what the physician indicated on the PAS and the testimony of the Appellant’s representatives regarding the Appellant’s mental health issues, nor was there any testimony as to whether dementia was the or the other mental disorders were the primary diagnosis.

The Respondent’s representative advised that a new PAS could be completed at any time by a physician of the Appellant’s choice. The “Level II” may be completed and could document more information regarding the Appellant’s mental health condition.

The Board of Review cannot judge the policy and can only determine if the Respondent followed the policy when deciding the Appellant’s Long-Term Care benefit eligibility based on the PAS submitted on May 4, 2026. The Appellant’s representatives showed by a preponderance of the evidence that the Appellant required physical assistance with dressing at the time of the PAS. The Appellant has one (1) additional deficit in addition to the two (2) awarded on the May 2026 PAS. The Respondent’s decision to deny the Appellant’s medical eligibility for long term care nursing facility services is affirmed.

CONCLUSIONS OF LAW

- 1) To be eligible for Long Term Care, the Appellant had to have five (5) deficits that met criteria at the time of the PAS.
- 2) The Appellant has frontotemporal dementia with Parkinsonian symptoms, seizures, and shoulder spasms, and requires physical assistance in dressing. The Appellant has a Level 2 deficit in this area.
- 3) The preponderance of the evidence revealed that the Appellant had three (3) deficits at the time of the PAS.
- 4) The preponderance of the evidence revealed that the physician did not indicate that the Level II mental health issues evaluation was required.

- 5) Because the Appellant did not have five (5) deficits that met criteria at the time of the PAS, the Respondent correctly denied the Appellant's Long Term Care eligibility.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's May 4, 2026 decision to deny the Appellant's medical eligibility for Long Term Care services.

ENTERED this 20th day of August 2026.

**Amy Hayes
State Hearing Officer
Member, Board of Review**