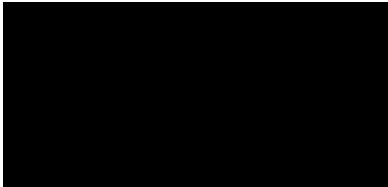




Ann Urling
Inspector General

August 19, 2026



RE: [REDACTED] v. WV DoHS/BFA
ACTION NO.: 26-BOR-2333

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
Melissa Grega – Acentra

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

[REDACTED]
Appellant,

v.

Action Number: 26-BOR-2333

**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 August 12, 2026.

The matter before the Hearing Officer arises from the Respondent's June 10, 2026 decision to deny the Appellant's eligibility for Medicaid Long-Term Care benefits.

At the hearing, the Respondent appeared by Terry McGee II, Bureau for Medical Services. Appearing as a witness for the Respondent was Melissa Grega, RN, Acentra. The Appellant was represented by [REDACTED] her son. Appearing as a witness for the Appellant was [REDACTED] her son. All witnesses were placed under oath, and the following documents were admitted into evidence.

Department's Exhibits:

- D-1 Exhibit Index
Acentra Notice of Denial, dated June 10, 2026
- D-2 Bureau for Medical Services Manual excerpt
- D-3 Pre-Admission Screening form, submitted June 8, 2026
- D-4 Medication List

Appellant's Exhibits:

- A-1 Daily Progress Note by [REDACTED] MD, on May 29, 2026
History and Physical Documentation, by [REDACTED] MD

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 Long-Term Care eligibility.
- 2) On June 10, 2026, the Respondent, by Acentra Health, issued a notice advising the Appellant her request for Medicaid Long-Term Care eligibility was denied because the Pre-Admission Screening (PAS) form failed to identify at least five (5) areas of care deficits that met the severity criteria. (Exhibit D-1)
- 3) The PAS revealed qualifying severe deficits in *bathing, incontinence, and orientation*. (Exhibits D-1 and D-3).
- 4) On May 29, 2026, the Appellant's physician, [REDACTED], MD, assessed the Appellant (Exhibits D-3 and A-1). [REDACTED] was present during the assessment at the Appellant's home.
- 5) Dr. [REDACTED] completed and submitted the PAS form on June 8, 2026. (Exhibit D-3)
- 6) Section 15 *Name and Address of Provider*, Section 21 *Normal Vital Signs*, Section 22 *Check if Abnormal*, and Section 27 *Professional and technical care needs* were left blank. (Exhibit D-3)
- 7) Section 23 *Medical conditions/symptoms* indicated severe Arthritis and severe pain. (Exhibit D-3)
- 8) Section 25 *In the event of an emergency, the individual can vacate the building* was marked, "With Supervision." (Exhibit D-3)
- 9) Section 26 *Indicate individual's functional ability in the home...* indicated the Appellant was totally disoriented. *Eating, dressing, and grooming* were indicated as Level 1 self/prompting. *Transferring and Walking* were indicated as Level 2 supervised/assistive device. (Exhibit D-3)
- 10) Section 28 *Individual is capable of administering his/her own medications* was marked, "with prompting supervision." (Exhibit D-3)
- 11) Under Section IV *Physician Recommendations*, Dr. [REDACTED] indicated the Appellant's prognosis was deteriorating, her rehabilitative potential was poor, and recommended nursing home placement only with no ability to return home or be discharged. (Exhibit D-3)

- 12) Dr. [REDACTED] indicated diagnoses including Major Neurocognitive Disorder due to Alzheimer's Disease; Moderate Vascular Dementia with psychotic disturbance; Primary Osteoarthritis involving multiple joints; and Absence of Bladder incontinence. (Exhibit D-3)
- 13) On May 29, 2026, Dr. [REDACTED] recorded in the physician's record that the Appellant has extremely poor cognition, hallucinations, and delusions. (Exhibit A-1)
- 14) On May 29, 2026, Dr. [REDACTED] recorded that the Appellant is "largely immobile and requires assistance for transfers and activities." Dr. [REDACTED] recorded that the Appellant has a history of multiple falls, including at least three requiring hospital visits and one rehabilitation stay. (Exhibit A-1)
- 15) On May 29, 2026, Dr. [REDACTED] recorded that the Appellant has a "gait problem," abnormal gait, and restricted motion in her lower extremity. (Exhibit A-1)
- 16) On May 29, 2026, Dr. [REDACTED] recorded that the Appellant has chronic knee pain, mild swelling in knees and feet, and experiences lower back pain. (Exhibit A-1)
- 17) On May 29, 2026, Dr. [REDACTED] recorded that the Appellant's symptoms have worsened over the past two to three years. (Exhibit A-1)
- 18) On May 29, 2026, Dr. [REDACTED] recorded that the Appellant has a urostomy bag changed every six weeks. (Exhibit A-1)
- 19) On May 29, 2026, Dr. [REDACTED] contacted a social worker for assistance placing the Appellant in a nursing home or assisted living facility. (Exhibit A-1)
- 20) On August 1, 2024, Dr. [REDACTED] evaluated the Appellant and recorded that the Appellant had worsening activities of daily living (ADL) and mobility dysfunction. (Exhibit A-1).
- 21) Dr. [REDACTED] recorded, "patient was relatively independent until recently and now requiring significant assistance with ADLs and transfers." (Exhibit A-1)
- 22) At the time of the PAS, the Appellant's urostomy bag required sterile dressing.
- 23) At the time of the PAS, the Appellant required physical assistance to comb her hair and put on a shirt.
- 24) At the time of the PAS, the Appellant required physical assistance with transferring and walking.
- 25) At the time of the PAS, the Appellant was cognitively unable to vacate the building in the event of an emergency. (Exhibit A-1)

26) At the time of the PAS, the Appellant required physical assistance brushing her hair, putting on a shirt, and tying her shoes.

APPLICABLE POLICY

Bureau for Medical Services (BMS) Manual § 514.5.1 *Application Procedures* provides that the medical eligibility determination is based on a physician's assessment of the medical and physical needs of the individual. The Pre-Admission Screening (PAS) assessment must have a physician's signature dated not more than 60 days before 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 that the PAS (level 1) 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.

Bureau for Medical Services (BMS) Manual § 514.5.3 *Medical Eligibility Regarding the PAS* 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.

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.
 - o Eating: Level 2 or higher (physical assistance to get nourishment...)
 - o Bathing: Level 2 or higher (physical assistance or more)
 - o Grooming: Level 2 or higher (physical assistance or more)
 - o Dressing: Level 2 or higher (physical assistance or more)
 - o Continence: Level 3 or higher (must be incontinent)
 - o Orientation: Level 3 or higher (totally disoriented, comatose)
 - o Transfer: Level 3 or higher (one person or two person assist in the home)
 - o Walking: Level 3 or higher (one person assistance in the home)
 - o 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

BMS Manual Chapter 514, Appendix B *Pre-Admission Screening* provides that for *eating*, *bathing*, *dressing* and *grooming*, Level 2 requires physical assistance. For *continence*: occasional incontinence is Level 2 and incontinence is Level 3. For *orientation*, Level 3 is

totally disoriented. For *transfer* and *walking*, Level 3 requires one-person assistance. For *wheeling*, Level 3 requires situational assistance.

DISCUSSION

The Appellant, by her representative, applied for eligibility for Medicaid Long-Term Care admission. On June 10, 2026, the Respondent, via Acentra, denied the Appellant's eligibility because the Pre-Admission Screening (PAS) form failed to identify the presence of five deficit areas that met severity criteria. According to the PAS, the Appellant was awarded qualifying severe deficits in *bathing*, *incontinence*, and *orientation*. The Appellant's representative argued that the Appellant should have received qualifying deficits in other areas.

The Board of Review cannot judge the policy and can only determine if the Respondent followed the policy when deciding the Appellant's Medicaid Long-Term Care benefit eligibility. Further, the Board of Review cannot make clinical determinations regarding the Appellant's functional ability and may only determine if the Respondent correctly concluded the Appellant's eligibility based on the severe deficits that were present at the time of the PAS. The Respondent had to prove by a preponderance of evidence that the Appellant's eligibility for Medicaid Long-Term Care admission was correctly denied because the Appellant did not have severe deficits in five areas at the time of the PAS.

On May 29, 2026, the Appellant's physician completed the PAS with the Appellant and her representative. During the hearing, reliable testimony and documentary evidence was provided that indicated the PAS omitted information about the Appellant's functioning. Although Dr. [REDACTED] PAS assessment did not indicate deficits in *transferring*, *walking*, *grooming*, *dressing*, *skilled needs*, or *vacating a building in the event of emergency*, the physician's records from the day of the assessment corroborated the testimony provided by Appellant's representative and witness regarding her functioning abilities at the time of the PAS. The evidence did not indicate that the Appellant had a *decubitus* at the time of the PAS.

To receive a deficit in *eating*, the Appellant had to require physical assistance to get nourishment. While testimony was provided regarding the need for assistance preparing the Appellant's food, the Appellant's representative and witness testified that the Appellant was physically capable of feeding herself bites of food. As no other evidence indicated the Appellant required physical assistance to eat, a deficit could not be awarded in this area.

For deficits to be awarded for *dressing* and *grooming*, the Appellant must require physical assistance to complete tasks in these areas. The Respondent's representative reliably testified that the Appellant could not lift her arms above her head and required physical assistance brushing her hair, putting on a shirt, and tying her shoes. Ms. Grega testified that based on the testimony provided, it was reasonable that the Appellant would also require physical assistance cutting her toenails. As the documentary evidence affirmed that the Appellant requires assistance completing her ADLs, the preponderance of evidence proved that the Appellant should have been awarded deficits in *grooming* and *dressing*.

To receive a deficit for *transfer* and *walking*, the Appellant had to require one or two-person assistance. Reliable testimony provided by the Appellant's representative and witness indicated that the Appellant required physical assistance transferring and walking, which was supported by the physician's documentation regarding the Appellant's abnormal gait, restricted motion in her lower extremity, and qualification as "largely immobile" and requiring assistance for transfers. Dr. [REDACTED] documented in 2024 that the Appellant had worsening activities of daily living (ADL), mobility dysfunction, and required significant assistance with ADLs and transfers. Dr. [REDACTED] recorded that the Appellant's symptoms have worsened over the past two to three years. As the preponderance of evidence revealed that at the time of the PAS, the Appellant required physical assistance transferring and walking, deficits should have been awarded for these areas.

For a deficit to be awarded in the area of *vacating in the event of an emergency*, the Appellant had to be physically or mentally unable to vacate the building. During the hearing, testimony from the Appellant's representative and witness indicated that the Appellant's cognitive status would prevent her from being able to acknowledge an emergency situation to vacate the building. Documentary evidence revealed that the Appellant was disoriented, had extremely poor cognition, and experienced hallucinations and delusions. Supporting testimony and physician's documentary evidence affirmed that the Appellant was physically unable to independently vacate the building in the event of an emergency. As the preponderance of evidence revealed that at the time of the PAS, the Appellant was cognitively and physically unable to vacate a building in the event of an emergency, a deficit should have been awarded in this area.

To be awarded a deficit in *skilled needs*, the Appellant had to require skilled needs in one or more areas, including suctioning, tracheostomy, ventilator, parenteral fluids, sterile dressings, or irrigations. During the hearing, the Appellant's representative argued that the Appellant's urostomy bag site required sterile dressing. The documentary evidence provided verified that the Appellant had a urostomy bag at the time of the PAS. Ms. Grega, the Respondent's witness, affirmed that if the information supplied were properly indicated on the PAS, the Appellant would have received a deficit in this area.

During the hearing, the Appellant's representative and witness testified that the Appellant is cognitively unable to take her medications. The Respondent's witness testified that the Appellant is physically able to place pills in her mouth but will occasionally refuse to take her medications due to her paranoid delusions or will throw them on the floor. The Respondent's policy does not offer a clear definition of criteria for medication self-administration. Instead, the Respondent defers to the Utilization Management Contractor (UMC) Acentra for deciding whether the applicant can self-administer medications based on the information provided by the physician completing the PAS. Although the PAS form does not specify whether physicians should consider physical or cognitive ability when assessing need for assistance with medication administration, Ms. Grega testified that ability is decided based on whether the applicant is physically capable of independently placing the medication in her mouth. There is no policy or information publicly available through the Respondent or Acentra to clarify why cognitive ability is precluded when determining an applicant's need for assistance with medication administration. Therefore, because the physician indicated on the PAS that the Appellant is physically capable of administering her own medications, and the documentary evidence did not present any evidence to refute the Appellant's ability, a deficit cannot be awarded in this area.

CONCLUSIONS OF LAW

- 1) To be eligible for Medicaid Long-Term Care admission, the Appellant had to demonstrate five (5) functional deficits at the time of the PAS.
- 2) The preponderance of evidence revealed that at the time of the PAS, the Appellant had severe deficits in *bathing, incontinence, orientation, grooming, dressing, orientation, transfer, walking, skilled needs, and requires emergency assistance/vacating*.
- 3) As the Appellant had at least five (5) functional deficits at the time of the PAS and met Medicaid Long-Term Care admission medical eligibility criteria, the Respondent's decision to deny his eligibility cannot be affirmed.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's decision to deny the Appellant medical eligibility for Medicaid Long-Term Care admission.

ENTERED this 19th day of August 2026.

**Tara B. Thompson, MLS
Certified State Hearing Officer**