WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 26-BOR-2679**

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 September 30, 2026, on an appeal filed with the Board of Review on September 8, 2026.

The matter before the Hearing Officer arises from the August 14, 2026 decision by the Respondent to deny the Appellant's admission for Long-Term Care (LTC) Medicaid assistance.

At the hearing, the Respondent appeared by Terry McGee, Program Manager-Bureau for Medical Services. Appearing as a witness for the Respondent was Melissa Grega, RN, Acentra. The Appellant was self-represented. All witnesses were placed under oath and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Notice of Decision dated August 14, 2026
D-2 Bureau of Medical Services Policy 514-Nursing Facility Services
D-3 Pre-Admission Screening dated August 12, 2026
D-4 Appellant prescriptions [redacted] Care Center

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 was a resident of [redacted] Care Center.

2) On August 12, 2026, the Pre-Admission Screening (PAS), a requirement to determine medical eligibility for LTC Medicaid assistance, was conducted by Jessica McColley, D.O. (Exhibit D-3)

3) The PAS documented no functional deficits.

4) On August 14, 2026, a Notice of Denial was issued to the Appellant citing that his request for LTC Medicaid assistance was denied because he did not receive the minimum required deficits to meet the severity criteria. (Exhibit D-1)

APPLICABLE POLICY

The Bureau for Medical Services (BMS) Provider Manual, §514.6.3, states:

> To qualify medically for the nursing facility Medicaid benefit, an individual must need direct nursing care 24 hours a day, 7 days a week. BMS has designed a tool known as the Pre-Admission Screening form (PAS) (see Appendix II) 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 BMS/designee in order to qualify for the Medicaid nursing facility benefit.
>
> These deficits may be any of the following:
>
> - #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) and b) are not considered deficits.
> - #26: Functional abilities of 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 assist 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 [*sic*] 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.

DISCUSSION

Medical eligibility for Long-Term Care Medicaid assistance is established when an individual requires direct nursing care twenty-four hours a day, seven days a week and has a minimum of five deficits identified on the PAS. The Appellant appealed the Respondent's decision to deny medical eligibility based on his failure to demonstrate the required deficits to meet the severity criteria. The Respondent must show by a preponderance of evidence that the Appellant did not meet the medical criteria in at least five areas of need.

On August 12, 2026, a PAS assessment was completed which failed to document any functional deficits in the evaluated life areas. The information submitted in the PAS failed to document at least five areas of care needs that met the severity criteria. Because the Appellant failed to meet the severity criteria, the Respondent denied the Appellant's medical eligibility for LTC effective August 14, 2026.

The Appellant testified that he suffered multiple strokes which renders the left side of his body paralyzed. The Appellant contends that an additional deficit should have been awarded in the area of dressing because he has difficulty tying his shoes due to the paralysis and requires assistance. The Appellant offered no other dispute to any of the evaluated areas citing that he obtains assistance with walking and transferring but is able to eat, bathe, groom by utilizing the right side of his body.

At the time of the PAS, the Appellant was assessed as a Level 1, Self/Prompting with his ability to dress. For a deficit to be awarded in the contested area, an individual must be assessed at a Level 2 or higher requiring physical assistance to complete the task. The Appellant provided credible testimony that he requires physical assistance to aid in dressing, especially with tying shoes, due to his paralysis. Therefore, testimony demonstrated the need for physical assistance to complete the task and an additional deficit in the life area **can be** awarded.

Based on an evidentiary review, one additional deficit was identified by the Appellant. The Appellant failed to meet the medical eligibility criteria of at least five required deficits in the area of care needs. Because the Appellant does not meet the medical eligibility criteria for Long-Term Care Medicaid assistance, the Respondent's decision to deny LTC Medicaid assistance is affirmed.

CONCLUSIONS OF LAW

1) An individual must have a minimum of five (5) deficits identified on the PAS to be determined medically eligible for the Long-Term Care Medicaid program.

2) The Appellant was awarded no deficits on the PAS assessment completed August 12, 2026.

3) Based on evidence, one additional deficit could be awarded in the area of dressing.

4) The Appellant does not meet the medical eligibility requirements for Long-Term Care Medicaid assistance.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to deny the Appellant's medical eligibility for Long-Tem Care Medicaid assistance.

ENTERED this _____ day of October 2026.

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Eric L. Phillips
State Hearing Officer