WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted]

Appellant,

v. **Action Number: 26-BOR-2918**

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 October 21, 2026, on an appeal filed with the Board of Review on September 28, 2026.

The matter before the Hearing Officer arises from the August 21, 2026, decision by the Respondent to deny medical eligibility for Long Term Care Medicaid.

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 witnesses for the Appellant were [redacted] and [redacted] The witnesses were placed under oath, and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Notice of Denial dated August 21, 2026
D-2 Bureau for Medical Services Provider Manual §514.5
D-3 Pre-Admission Screening dated August 19, 2026
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 Medicaid benefits.

2) On August 19, 2026, a Pre-Admission Screening (PAS) was completed for the Appellant to determine medical eligibility for Long Term Care Medicaid (Exhibit D-3).

3) The Appellant was awarded deficits in *bathing, dressing,* and *vacating a building in an emergency* (Exhibit D-3).

4) The Respondent sent a notice on August 21, 2026, advising the Appellant that the documentation did not reflect at least five deficits at the level required, therefore eligibility for Long Term Care services was denied (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 care24 hours a day, seven days a week. The State 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 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 persons 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 Long Term Care 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.

The Appellant was evaluated for Long Term Care Medicaid, and a medical assessment was completed on August 19, 2026, to determine medical eligibility for the program. The Appellant was awarded three deficits on the August 2026 PAS, in *bathing, dressing,* and *vacating a building in an emergency*. The Appellant contested not receiving deficits in *medication administration, walking, hearing, and bladder continence.*

Medication Administration

The Appellant was assessed as able to administer medications with prompting/supervision. The Appellant testified that he takes up to twenty medications daily and he needs assistance ensuring that he takes the correct dose. The Appellant stated he cannot keep up with his medications and has taken the incorrect dosage in the past. To receive a deficit in *medication administration*, the Appellant would need physical assistance in administering his medications. No testimony was provided regarding the Appellant's inability to self-administer medication therefore he was correctly assessed as requiring prompting/supervision in this area which does not constitute a deficit in *medication administration*.

Hearing

The Appellant was assessed as correctable/not impaired in the area of *hearing*. The Appellant testified that he has difficulty hearing and should have received a deficit. Although *hearing* is evaluated on the PAS, *hearing* is not an area in which a deficit can be awarded.

Bladder Continence

The Appellant testified that he has an overactive bladder and has bladder accidents almost daily. The Appellant stated he uses incontinence briefs and will have bladder surgery in the upcoming months. Based on the Appellant's credible testimony regarding bladder incontinence, coupled with documentation of prescribed medication for an overactive bladder, the Appellant will be awarded a deficit in *bladder continence*.

Walking

The Appellant testified that when he is able to ambulate, he uses a walker. The Appellant stated he is unsteady and has a history of falls and due to arthritis in his back, most days he does not have the strength to support himself using a walker. The Appellant contended that he mostly uses a wheelchair to ambulate. The Appellant was assessed as being physically unable to *vacate a building in an emergency*, lending credibility to the Appellant's claim that he cannot walk without physical assistance. The Appellant will be awarded a deficit in *walking*.

Whereas deficits in *bladder continence* and *walking* were identified for the Appellant, the Appellant meets the medical eligibility criteria to receive Long Term Care Medicaid benefits.

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 three deficits on the August 2026 Pre-Admission Screening.

3) The documentation and testimony established two additional deficits for the Appellant, in *bladder continence* and *walking*.

4) The Appellant meets the medical eligibility criteria for Long Term Care 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 benefits.

ENTERED this 28th day of October 2026.

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Kristi Logan
Certified State Hearing Officer
Member, Board of Review