July 10, 2024

[redacted]

RE: [redacted], A PROTECTED INDIVIDUAL v. WV DoHS/BMS
ACTION NO.: 24-BOR-1884

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,

Tara B. Thompson, MLS
State Hearing Officer
Member, State Board of Review

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

cc: Kesha Walton, Bureau for Medical Services
Terry McGee, Bureau for Medical Services

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted] A PROTECTED INDIVIDUAL,

Appellant,

v. **Action Number: 24-BOR-1884**

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] a protected individual. 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 June 18, 2024.

The matter before the Hearing Officer arises from the Respondent's March 18, 2024 decision to deny the Appellant's Medicaid Long-Term Care Admission eligibility.

At the hearing, the Respondent was represented by Terry McGee, II, Bureau for Medical Services (BMS). Appearing as a witness for the Respondent was Melissa Grega, RN, Acentra. The Appellant was represented by [redacted]. Appearing as witnesses for the Appellant were [redacted] Social Services staff; and [redacted] Care Plan Coordinator. All representatives and witnesses were placed under oath and the following exhibits were submitted as evidence:

Department's Exhibits:
D-1 Notice, dated April 11, 2024
Notice of Denial for Long-Term Care, dated March 18, 2024
D-2 Bureau for Medical Services Chapter 514 excerpts
D-3 Pre-Admission Screening form, submitted March 18, 2024
D-4 Medication List

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 admitted to [redacted] on February 19, 2024, and was previously approved for Medicaid LTC admission based on a January 31, 2024 PAS (Exhibit D-3).

2) On March 18, 2024, the Respondent issued a notice advising the Appellant his request for Medicaid LTC admission had been denied because the Pre-Admission Screening form failed to identify five areas of care that met the severity criteria (Exhibit D-1).

3) The March 18, 2024 notice reflected the presence of a severe deficit in *medication administration* (Exhibit D-1).

4) On March 18, 2024, [redacted] MD, completed a Pre-Admission Screening (PAS) with the Appellant (Exhibit D-3).

5) The Appellant's Medicaid LTC eligibility was automatically adjudicated by the Respondent's computer system based on the information submitted on the PAS.

6) At the time of the PAS, the Appellant had a severe deficit in *orientation*.

7) At the time of the PAS, the Appellant required physical assistance vacating the building during an emergency.

8) At the time of the PAS, the Appellant required physical assistance with bathing.

9) At the time of the PAS, the Appellant required physical assistance with grooming.

10) At the time of the PAS, the Appellant did not have a decubitus (Exhibit D-3).

11) At the time of the PAS, the Appellant required physical assistance *eating.*

12) At the time of the PAS, the Appellant did not require physical assistance *transferring* or *walking* (Exhibit D-3).

13) At the time of the PAS, the Appellant was continent of bladder and bowel (Exhibit D-3).

14) On the PAS, the physician checked that the Appellant has exhibited *disoriented* and *seriously impaired judgment* in the past two years (Exhibit D-3).

15) Under *Physician Recommendation*, the physician checked *stable* prognosis; and *limited* rehabilitative potential (Exhibit D-3).

16) Under *Physician Recommendation*, the physician indicated the Appellant was suitable for nursing facility placement only and would not eventually be able to return home or be discharged (Exhibit D-3).

17) Under *Physician Recommendation*, the physician indicated that the Appellant's recommended services and care to meet her needs could be provided at the *Nursing Home* level of care (Exhibit D-3).

APPLICABLE POLICY

Bureau for Medical Services (BMS) Manual § 514.5.1 *Application Procedures* provides in relevant sections: 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 in relevant sections: 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 in relevant sections: 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.
    - Eating: Level 2 or higher (physical assistance to get nourishment…)
    - 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 assistance in the home)
- 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 in relevant sections: For *eating*, *bathing*, 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 was previously approved in January 2024 for long-term care admission. In March 2024, the Respondent denied the Appellant's medical eligibility because the PAS did not identify the presence of severe deficits in five functioning areas. The PAS revealed the presence of deficits in one (1) area: *medication administration*. Following testimony presented by the Appellant's witnesses, the Respondent stipulated that the Appellant had severe deficits in two (2) additional areas — *orientation* and *requires emergency assistance/ vacating* — and should have received deficits in those areas at the time of the PAS.

The Board of Review cannot judge the policy and can only determine if the Respondent followed the policy when deciding the Appellant's Medicaid LTC 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 LTC admission was correctly denied because the Appellant did not have severe deficits in five areas at the time of the PAS.

During the hearing, reliable testimony was provided that indicated the PAS omitted information about the Appellant's diagnoses and functioning. The Appellant's witness testified the Appellant has diagnoses including diabetes, intellectual/developmental disability, and dementia. The Respondent testified that diagnoses alone do not qualify as deficits and that the evaluating physician must determine how the Appellant is affected by his diagnoses.

The Appellant's witness testimony indicated his history of severe neglect due to the mental limitations related to his diagnosis. The testimony provided that the Appellant requires physical

assistance to get nourishment. Because the Appellant required physical assistance to get nourishment at the time of the PAS, a deficit should have been awarded for *eating*.

Reliable testimony was provided to establish that the Appellant required physical assistance with grooming and bathing at the time of the PAS. The Appellant's witnesses testified that he needs physical assistance shaving and brushing his teeth. Testimony was provided that the Appellant is a fall risk due to balance issues and muscle weakness. Because the Appellant required physical assistance to conduct *bathing* and *grooming* at the time of the PAS, deficits should have been awarded in these areas.

Testimony was provided regarding assisting the Appellant with putting on his coat. While he requires physical assistance for this article of clothing, no additional testimony was provided to indicate that the Appellant required other physical assistance in daily dressing activities. Because the preponderance of evidence did not reveal the necessity of physical assistance in completing daily dressing activities, a severe deficit could not be identified for *dressing*.

As the PAS only indicated severe deficits in one area, the physician's recommendations contradict the PAS assessment of the Appellant's functioning. The reliable testimony provided during the hearing regarding the Appellant's functioning was consistent with the physician's recommendation for nursing home placement.

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. No evidence was entered to indicate that the Appellant had any of these skilled needs. No additional evidence was submitted to indicate the Appellant should have received severe deficits in any other areas.

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 *medication administration, eating, grooming, bathing, orientation,* 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 March 18, 2024 decision to deny the Appellant medical eligibility for Medicaid Long-Term Care admission. It is

hereby **ORDERED** the Appellant's Medicaid LTC eligibility be instated retroactively to the date of denial.

ENTERED this 10th day of July 2024.

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Tara B. Thompson, MLS
State Hearing Officer