July 10, 2024

[redacted]

RE: [redacted] v. WV DoHS/BMS
ACTION NO.: 24-BOR-2358

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,

Lori Woodward, J.D.
Certified State Hearing Officer
Member, State Board of Review

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

cc: Terry McGee/Kesha Walton, WV DOHS/BMS

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 24-BOR-2358**

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 West Virginia Office of Inspector General Common Chapters Manual. This fair hearing was convened on July 10, 2024.

The matter before the Hearing Officer arises from the Respondent's denial of Long-Term Care Medicaid benefits as outlined in a notice dated March 7, 2024.

At the hearing, the Respondent appeared by Terry McGee, Program Manager, Long-Term Care Facilities, WV DOHS/BMS. Appearing as a witness for the Respondent was Melissa Grega, Nurse Reviewer, Acentra Health. The Appellant appeared *pro-se*. Appearing as witnesses for the Appellant were [redacted] Social Worker, [redacted] Center, and [redacted], Business Office Manager, [redacted] Center. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

- D-1 Notice of Decision dated March 7, 2024
- D-2 Bureau for Medical Services Provider Manual Chapter 514.6* (outdated)
- D-3 Pre-Admission Screening dated March 6, 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 has been a resident at [redacted] Center [redacted] since March 2023. (Exhibit D-3)

2) The Appellant's physician completed a Pre-Admission Screening (PAS) for the Appellant on March 6, 2024. (Exhibit D-3)

3) The Respondent sent the Appellant a Notice of Decision on March 7, 2024, informing him that Long-Term Care Medicaid services were denied. (Exhibit D-1)

4) The Notice states that three (3) deficits were awarded to the Appellant in the functional areas of dressing, incontinence, and assistance with vacating in an emergency. (Exhibit D-1).

APPLICABLE POLICY

Bureau of Medical Services (BMS) Manual, Chapter 514, 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 DHHR 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, Chapter 514, §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.

BMS Manual, Chapter 514, §514.5.3 Medical Eligibility Regarding the Pre-Admission Screening, in part:

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 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

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.

DISCUSSION

The Appellant is currently a resident of [redacted] who underwent an assessment on March 6, 2024. The findings from this assessment were recorded on a Pre-Admission Screening (PAS) document completed by a physician from the facility, [redacted]. This document was reviewed by the Respondent's assessing nurse to determine the number of deficits that meet the LTC Medicaid policy severity criteria for medical eligibility. Five deficits are required to establish medical eligibility for LTC Medicaid. The Appellant was assessed with three substantial deficits in the areas of *Dressing, Incontinence,* and *vacating a building in the event of an emergency.*

On March 7, 2024, the Respondent sent the Appellant notification that his application for LTC Medicaid had been denied based on not meeting at least five areas of care needs (deficits) that meet the severity criteria for eligibility.

Neither the Appellant nor his witnesses contested the findings on the March 2024 PAS. No additional deficits were proffered at the hearing. Instead, the Appellant's witnesses discussed the Appellant's lack of financial resources to pay for his stay at [redacted]. Additionally, the Appellant's witnesses testified that [redacted] has been unable to find options for the Appellant's looming discharge from the Facility.

The issue at the hearing was the Respondent's finding that the Appellant did not meet the medical eligibility criteria established by policy for LTC Medicaid. Financial eligibility or discharge from the Nursing Facility were not at issue. The Hearing Officer must determine whether the Respondent followed policy in denying the Appellant LTC Medicaid benefits based on medical eligibility criteria and lacks authority to change or provide exceptions to the policy.

Policy requires that an individual have at least a minimum of five deficits identified on the PAS to qualify medically for LTC Medicaid benefits. The Appellant did not establish that he had any additional substantial deficits that should have been awarded on the March 2024 PAS during the hearing. Because the Appellant failed to establish a minimum of five deficits on the March 2024 PAS assessment, the Respondent's decision to deny the Appellant's LTC Medicaid application is affirmed.

CONCLUSIONS OF LAW

1) To medically qualify for Long-Term Care Medicaid benefits, an individual must have a minimum of five deficits identified on the Pre-Admission Screening form.

2) The Appellant received three deficits on a PAS completed in March 2024.

3) No additional substantial deficits were established at the hearing.

4) The Respondent correctly denied the Appellant's medical eligibility for Long-Term Care Medicaid benefits.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's action to deny Long-Term Care Medicaid benefits.

ENTERED this 10th day of July 2024.

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Lori Woodward, Certified State Hearing Officer