September 4, 2024

[redacted]

RE: [redacted] v. WV DoHS/BMS
ACTION NO.: 24-BOR-2490

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-2490**

WV 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 originally set to be heard on July 31, 2024, but upon the request of the Appellant and agreement of the parties, it was convened on August 27, 2024.

The matter before the Hearing Officer arises from the Respondent's decision to deny medical eligibility for Long Term Care (LTC) Medicaid as outlined in the Notice dated May 29, 2024.

At the hearing, the Respondent appeared by Terry McGee, Program Manager, Bureau of Medical Services. Appearing as a witness for the Respondent was RN Melissa Grega, Nurse Reviewer, Acentra Health. The Appellant was represented by counsel, [redacted] The Appellant testified on his own behalf. All witnesses were placed under oath and the following documents were admitted into evidence.

Department's Exhibits:

- D-1 Notice of Decision dated May 29, 2024
- D-2 Acentra Health Policy, Chapter §514.6
- D-3 Pre-Admission Screening (PAS) form dated May 28, 2024
- D-4 Medication List

Appellant's Exhibits:

Note: At the conclusion of the hearing, the Appellant's counsel requested a late submission of a July 2024 PAS. It was denied due to the lateness of the request and the relevance to the issue of the May 29, 2024 denial. See discussion below.

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] since April 2023.

2) An assessment of the Appellant was documented in a Pre-Admission Screening (PAS) form completed on May 28, 2024, by [redacted] and reviewed by Melissa Grega, the Respondent's nurse reviewer. (Exhibit D-3)

3) At the time of the May 2024 PAS, the Appellant had no decubitus and was able to independently vacate a building in case of emergency. (Exhibit D-3)

4) At the time of the May 2024 PAS, the Appellant was found to have Level 1 capabilities in the areas of eating, bathing, dressing, grooming, continence of bladder, transferring orientation, wheeling, vision, and hearing. (Exhibit D-3)

5) At the time of the May 2024 PAS, the Appellant was found to have Level 2 capabilities in the areas of bowel continence (occasional incontinent) and walking (supervised/assistive devise [stet]) - a level 3 or higher is needed to qualify as a deficit for medical eligibility. (Exhibits D-2 and D-3)

6) At the time of the May 2024 PAS, the Appellant was able to administer his own medications with prompting supervision. (Exhibits D-2 and Exhibit D-3)

7) At the time of the May 2024 PAS, the Appellant did not require skilled needs in suctioning, tracheostomy, ventilator, parenteral fluids, sterile dressings, or irrigations (Exhibits D-2 and D-3).

8) The Appellant's May 2024 PAS revealed no deficits as defined by medical eligibility policy. (Exhibits D-2 and D-3)

9) On May 29, 2024, the Respondent issued a notice to the Appellant advising him that he was medically ineligible for LTC Medicaid benefits based upon WV Medicaid criteria. (Exhibit D-1)

10) The May 29, 2024 notice advised the Appellant that his (May 28, 2024) PAS failed to identify any areas of deficits that met the severity criteria. (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

Approval for the Respondent's LTC (Nursing Home) Medicaid program involves a financial and medical determination of eligibility. The financial eligibility determination is made by the Department of Human Services (DoHS) Bureau of Family Assistance (BFA). The medical eligibility determination is made by the DoHS Bureau for Medical Services (BMS). On appeal is the Respondent's May 29, 2024 finding of medical ineligibility for the LTC Medicaid program.

To qualify medically for the LTC 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 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 LTC Medicaid benefit.

The Appellant is currently a resident of [redacted] who underwent a PAS assessment on May 28, 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 nurse reviewer to determine the number of deficits that met the LTC Medicaid policy severity criteria for medical eligibility. At least five severe deficits are required to establish medical eligibility for LTC Medicaid. The Appellant had no identified deficits that met the severity level established by policy on his May 2024 PAS. On May 29, 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 medical eligibility.

The Respondent had to prove by a preponderance of evidence that the Appellant's eligibility for LTC Medicaid was correctly denied because the Appellant did not have severe deficits in at least five areas at the time of the May 28, 2024 PAS.

Nurse Grega, testified that the May 2024 PAS, upon which the Respondent's decision was made, failed to show any areas of deficits that met the severity level needed for medical eligibility for LTC. Specifically, the Appellant was able to independently vacate a building in the case of emergency and was found to have Level 1 capabilities in the areas of eating, bathing, dressing,

grooming, continence of bladder, transferring, orientation, wheeling, vision, and hearing. With the exception of bladder incontinence which requires a Level 3, these Level 1 areas all require at least a Level 2 to qualify as a deficit. The Appellant received a Level 2 in the areas of continence of bowel and walking. Policy requires that an individual have a Level 3 or higher in these areas to qualify as a deficit - total incontinence of bowel and a one-person assistance with walking. The Appellant testified that he is able to ambulate with a cane, can bend down and touch his toes, and is able to administer his own medications.

It is noted that the testimony showed that another PAS was performed in July 2024 for another program. The Appellant's counsel proffered that the July 2024 PAS awarded the Appellant three deficits. Five substantial deficits are required to meet medical eligibility for the LTC Medicaid program. The July 2024 PAS would not impact the Appellant's medical eligibility for the LTC Medicaid program. Moreover, information relevant to the Appellant's functional abilities at the time of the May 28, 2024 PAS may only be considered by the Hearing Officer and therefore was not found relevant to the Appellant's functioning at the time of the PAS. It was also noted that Counsel was granted a 30-day continuance in order to prepare for this hearing. There was ample time to submit exhibits prior to the hearing. For these reasons, Counsel's motion to enter the July 2024 PAS for the record was denied.

There was no testimony or evidence presented to show that the Appellant's condition was other than what was recorded on the May 28, 2024 PAS. Instead, the Appellant testified to his lack of income, inability for gainful employment, and being unable to move back to the home where he previously resided. Financial eligibility or lack of housing are not considerations for determining medical eligibility for the LTC Medicaid program. The Board of Review cannot judge the policy and can only determine if the Respondent followed the policy when deciding the Appellant's LTC Medicaid eligibility. Additionally, the Board of Review cannot make clinical determinations regarding the Appellant's functional ability and can only decide if the Respondent correctly concluded the Appellant's eligibility based on the submitted documentation.

The PAS did not indicate the presence of any functioning deficits at the time of the Respondent's May 29, 2024 denial of the Appellant's medical eligibility for the LTC Medicaid program. Because the preponderance of the evidence revealed the Appellant did not have severe functioning deficits in at least five policy-identified areas of functioning at the time of the May 2024 PAS, the Respondent's decision to deny the Appellant medical eligibility for LTC was correct.

CONCLUSIONS OF LAW

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

2) The preponderance of evidence showed that the Appellant had no substantial deficits at the time his May 2024 PAS was completed.

3) Because the Appellant did not have at least five deficits identified at the time of his May 2024 PAS, the Respondent must deny the Appellant's medical eligibility for LTC Medicaid benefits.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to deny LTC Medicaid benefits.

ENTERED this 4th day of September 2024.

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Lori Woodward, Certified State Hearing Officer