December 16, 2024

[redacted]

RE: [redacted]
ACTION NO.: 24-BOR-3477

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 assure 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,

Angela D. Signore
State Hearing Officer
Member, State Board of Review

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

Cc: Terry McGhee, Bureau for Medical Services
Kesha Walton, Bureau for Medical Services

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 24-BOR-3477**

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 December 3, 2024, on an appeal filed October 15, 2024.

The matter before the Hearing Officer arises from the August 7, 2024, decision by the Respondent to deny medical eligibility for Long Term Care Medicaid benefits.

At the hearing, the Respondent appeared by Terry McGee II, Program Manager I, Bureau for Medical Services Appearing as a witness on behalf of the Respondent was [redacted] Acentra. The Appellant appeared *pro se.* All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Notice of Denial, dated October 7, 2024
D-2 Bureau for Medical Services (BMS) Chapter 514 Nursing Facility Services Policy
D-3 Pre-Admission Screening (PAS), created October 04, 2024
D-4 [redacted] 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 is a recipient of Long-Term Care (LTC) Medicaid benefits and has resided at [redacted] since July 29, 2024. (Exhibits D-3 and D-4)

2) On October 04, 2024, a PAS was submitted to determine the Appellant's eligibility for continued LTC services. (Exhibits D-1 and D-3)

3) By notice dated October 07, 2024, the Respondent advised the Appellant that she was "ineligible for long-term care (nursing facility) admission based upon WV Medicaid criteria." (Exhibit D-1)

4) The October 07, 2024 denial was based on "documentation does not reflect that you have five (5) deficits at the level required." The notice indicated the Appellant had one (1) deficit, and the policy requires at least five (5) deficits. (Exhibits D-1 through D-3)

5) The Appellant was assessed as having a deficit in the area of *professional and technical care needs*. (Exhibits D-1 and D-3)

6) At the time of the PAS, the Appellant did not have deficits that met the severity criteria in the areas of *decubitus, medication administration, eating, grooming, bathing, dressing, incontinence, orientation, transfer, walking, wheeling,* or *requires emergency assistance/vacating*. (Exhibits D-1 and D-3)

7) The physician's recommendations on the October 04, 2024 PAS read, "FOR NURSING FACILITY PLACEMENT ONLY: On the basis of present medical findings, the individual may eventually be able to return home or be discharged – Yes. a. Less than 3 months - Please specify estimated length of stay (in calendar days): 30." (Exhibit D-3)

APPLICABLE POLICY

Bureau for Medical Services (BMS) Manual § 514.5.3 provides, 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 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 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 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

DISCUSSION

Pursuant to policy, all Long-Term Care (LTC) programs require a determination of medical eligibility. To qualify medically for Medicaid nursing facility benefits, an individual must need direct nursing care twenty-four (24) hours a day, seven (7) days a week. The Bureau for Medical Services has designated a tool known as the Pre-Admission Screening (PAS) to be utilized for physician certification of the medical needs of individuals applying for LTC Medicaid benefits. The Appellant, a Resident of [redacted] was admitted on July 29, 2024 on a short-term basis after hospitalization. On October 04, 2024, a PAS was submitted to determine the Appellant's eligibility for continued nursing facility services. On October 07, 2024, a Notice of Denial for LTC Medicaid benefits was issued to the Appellant advising that she did not meet the eligibility criteria threshold of five (5) functional deficits, as required by policy, to qualify for continued nursing facility services. Per policy, the Appellant must have five (5) functional deficits at the time the PAS was completed in order to qualify medically for continued nursing facility services. Acentra, the Utilization Management Contractor (UMC) responsible for conducting medical necessity reviews of the PAS, assessed the Appellant with one (1) deficit in the functional area of *professional and technical care needs*. The Respondent had to demonstrate by a preponderance of evidence that the UMC followed policy in determining the Appellant's medical eligibility for LTC Medicaid benefits.

During the hearing, the Appellant testified that she needs help with *bathing*, *dressing*, and *grooming* due to the removal of a boil under her arm that causes numbness. She further testified that it also requires the application of sterile dressings and reasoned that a deficit should have been awarded in all three (3) areas since washing her hair is "really hard with only one hand." She further testified that she needs assistance with brushing her hair, and washing her feet, back, and bottom areas. She further testified that she is currently receiving physical therapy on her legs and

argued that additional therapy is needed for her back, her hips, and her arms. The Appellant further testified that the only *walking* she does is from the door of her bathroom to the toilet. She argued that an additional deficit should have been awarded in the functional area of *requires emergency assistance/vacating* since she would be slow to vacate in an emergency due to only having use of "one arm and one leg." She further testified that she is unable to walk using a walker and has moments of incontinence where she requires assistance with dressing. No further areas were contested by the Appellant at the time of the hearing. When deciding the Appellant's Medicaid LTC benefit eligibility, the Board of Review cannot judge the policy and can only determine if the Respondent followed the policy. Further, the Board of Review cannot make clinical determinations regarding the Appellant's functional ability and may only determine if the Respondent correctly assessed the Appellant's eligibility at the time of the PAS.

To be eligible for a deficit in the functional areas of *bathing, grooming* and *dressing*, the PAS had to reflect a Level 2 or higher functioning ability that requires physical assistance, or more. When reviewing the PAS, the Appellant was Level 1 – self/prompting in all three functional areas. No evidence was entered to establish that the Appellant should have been assessed as a Level 2 or higher, at the time the PAS was completed. To be eligible for a deficit in the functional areas of *walking* and *wheeling*, the PAS had to reflect a Level 3 or higher functioning ability that requires physical assistance, or more. Pursuant to the PAS, the Appellant was assessed as a Level 2 – supervised/assistive device with *walking*, and a Level 2 – wheels independently in the functional area of *wheeling*. The Appellant's argument that numbness underneath her arm caused by the boil removal limiting her ability to bathe, groom, or dress is unconvincing. Because the PAS did not reflect any evidence that the information provided was unreliable or that the Appellant should have been awarded additional deficit areas at the time of the PAS, additional deficits cannot be awarded in these areas.

To be eligible for a deficit in the functioning area of *continence*, the PAS had to reflect a Level 3 or higher functioning ability of incontinence. Pursuant to the PAS, the Appellant is Level 1 - continent. No further evidence was entered to establish that the Appellant presented with Level 3 or higher incontinence. To be eligible for a deficit in the functioning area of *requires emergency assistance/vacating*, the PAS had to reflect that the Appellant is mentally or physically unable to vacate a building. While the Appellant provided testimony that she can only wheel with one leg and one arm, the PAS reflects that in the functional area of *wheeling*, she is a Level 2 – wheels independently, and that the Appellant is able to vacate the building independently. Since the Appellant's testimony does not corroborate the information provided on the PAS, additional deficits cannot be awarded. Therefore, because the Appellant failed to meet the five (5) deficit threshold, she no longer meets the medical criteria to continue receiving Long-Term Care Medicaid benefits.

CONCLUSIONS OF LAW

1) Policy requires that an applicant must demonstrate five (5) functional deficits on the Pre-Admission Screening (PAS) to qualify medically for Long-Term Care (LTC) Medicaid benefits.

2) The preponderance of evidence revealed that the Appellant was correctly assessed with one (1) deficit in the functional area of *professional and technical care needs.*

3) Because the Appellant did not meet the five (5) deficit threshold at the time of the PAS, the Respondent correctly denied the Appellant's medical eligibility for Medicaid LTC benefits.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to deny the Appellant's October 04, 2024, application for Long-Term Care (LTC) Medicaid benefits.

ENTERED this _____ day of December 2024.

_____

Angela D. Signore
State Hearing Officer