December 20, 2024

[redacted]

RE: [redacted] v. WVDoHS-BUREAU FOR MEDICAL SERVICES
ACTION NO.: 24-BOR-3688

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,

Eric L. Phillips
State Hearing Officer
Member, State Board of Review

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

cc: BMS

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 24-BOR-3688**

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 19, 2024, on an appeal filed November 15, 2024.

The matter before the Hearing Officer arises from the October 30, 2024 decision by the Respondent to deny Long-Term Care Medicaid admission.

At the hearing, the Respondent appeared by Terry McGee II, Program Manager. Appearing as a witness for the Respondent was Melissa Grega, Nurse Reviewer, Acentra. The Appellant appeared pro se. Appearing as a witness was [redacted] Social Worker, [redacted]. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Notice of Decision dated October 30, 2024
D-2 Bureau of Medical Services Policy 514-Nursing Facility Services
D-3 Pre-Admission Screening dated October 29, 2024

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 resident at the [redacted]

2) The Appellant's medical eligibility was assessed for continued Long-Term Care (LTC) Medicaid assistance.

3) On October 29, 2024, a Pre-Admission Screening (PAS), a requirement to determine medical eligibility for LTC Medicaid assistance, was conducted by [redacted]

4) The PAS documented functional deficits in the areas of bathing and grooming.

5) On October 30, 2024, a Notice of Denial (Exhibit D-1) was issued to the Appellant citing that his request for LTC Medicaid assistance was denied because he did not receive the minimum required deficits to meet the severity criteria.

APPLICABLE POLICY

The Bureau for Medical Services (BMS) Provider Manual, §514.6.3, states:

> To qualify medically for the nursing facility Medicaid benefit, an individual must need direct nursing care 24 hours a day, 7 days a week. BMS has designed a tool known as the Pre-Admission Screening form (PAS) (see Appendix II) 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 BMS/designee in order to qualify for the Medicaid nursing facility benefit.
>
> These deficits may be any of the following:
>
> - #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 assist 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 [*sic*] 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

Medical eligibility for Long-Term Care Medicaid assistance is established when an individual requires direct nursing care twenty-four hours a day, seven days a week and has a minimum of five deficits identified on the PAS. The Appellant appealed the Respondent's decision to deny medical eligibility based on his failure to demonstrate the required deficits to meet the severity criteria. The Respondent must show by a preponderance of the evidence that the Appellant did not meet the medical criteria in at least five areas of need.

On October 29, 2024, a PAS assessment was completed which documented that the Appellant met the criteria for a functional deficit in the areas of bathing and grooming. The information submitted in the PAS assessment failed to document at least five areas of care needs that met the severity criteria. Because the Appellant failed to meet the severity criteria, the Respondent denied the Appellant's medical eligibility for LTC, effective October 30, 2024.

[redacted] Social Worker, [redacted] testified that the Appellant's PAS assessment was derived from the totality of his nursing reports while at the facility and the documentation was submitted for approval to the Facility's physician, [redacted] indicated that upon receipt of the Medicaid termination (Exhibit D-1), the PAS assessment was reviewed with the Facility's Associate Director of Nursing and the Ombudsman with all parties concluding that the Appellant failed to demonstrate the required minimum deficits. [redacted] indicated that the Appellant has demonstrated an overall improvement with his health and that his deficits differ from his admission date to present day.

The Appellant questioned the validity of the PAS assessment and contended that an additional deficit should be awarded in the area of walking. The Appellant indicated that he was a participant in physical therapy at the Facility. [redacted] added that the Appellant completed physical therapy on December 2, 2024, and that the Appellant can "ambulate with a rolling walker up to 100 feet utilizing a rolling in the [Facility] hallway." [redacted] opined that the Appellant desired to ambulate with a cane but is not sufficient [sic] with its use.

Governing policy mandates that the assessment tool must be completed, signed and dated by the physician and reviewed by the Bureau of Medical Services, or its designee, for a medical necessity review. Evidence reveals that information for the Appellant's PAS assessment was compiled by the Facility staff and reviewed, then approved by the Facilities physician. Based on evidence presented during the hearing, the assessment was a valid interpretation of the Appellant's functional abilities because it was derived from complete nursing notes from the Facility.

Additionally, governing policy requires that a deficit can be awarded in the area of walking, when an individual requires physical assistance to aide in ambulation. Evidence reveals that the Appellant's ambulation was assessed as requiring supervision and an assistive device. Based on testimony provided during the hearing, the Appellant can ambulate with an assistive device but failed to support the Appellant's need for physical assistance with ambulation. Therefore, the Appellant was correctly assessed in regard to his ambulation and an additional deficit in the contested area cannot be awarded. The Appellant provided no other testimony regarding additional areas in which he should have been awarded a functional deficit on the October 29, 2024, PAS assessment.

Whereas two deficits were identified for the Appellant as a result of the October 29, 2024, PAS assessment, the Appellant does not meet the medical eligibility criteria for Long Term Care Medicaid.

CONCLUSIONS OF LAW

1) An individual must have a minimum of five (5) deficits identified on the PAS to be determined medically eligible for the Long-Term Care Medicaid program.

2) The Appellant was awarded two (2) deficits on the PAS assessment completed October 29, 2024.

3) Based on evidence, no additional deficits were awarded in the functional areas.

4) The Appellant does not meet the medical eligibility requirements for Long-Term Care Medicaid assistance.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to deny the Appellant's medical eligibility for Long-Term Care Medicaid assistance.

ENTERED this _____ day of December 2024.

_____

Eric L. Phillips
State Hearing Officer