January 3, 2025

[redacted]

RE: [redacted], A PROTECTED INDIVIDUAL v. MCDOWELL HEALTHCARE CENTER
ACTION NO.: 24-BOR-3843

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 McGee, Bureau for Medical Services
Kesha Walton, Bureau for Medical Services

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted] A PROTECTED INDIVIDUAL,

Appellant,

v. **Action Number: 24-BOR-3843**

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 D.C., 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 December 26, 2024, on an appeal filed December 10, 2024.

The matter before the Hearing Officer arises from the November 20, 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 Melissa Grega, RN, Acentra. The Appellant was represented by [redacted]. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Notice of Denial, dated November 20, 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 resides at [redacted]. (Exhibits D-3 and D-4)

2) On November 18, 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 November 20, 2024, the Respondent advised the Appellant that he was "ineligible for long-term care (nursing facility) admission based upon WV Medicaid criteria." (Exhibit D-1)

4) The November 20, 2024 denial was based on insufficient areas of care needs, or deficits, that failed to "meet the severity criteria." The notice indicated the Appellant had zero (0) deficits, and the policy requires at least five (5) deficits. (Exhibits D-1 through D-3)

5) No functional deficits were identified on the Appellant's November 18, 2024, PAS. (Exhibits D-1 and D-3)

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

7) At the time of the November 2024 PAS, the Appellant was able to administer his own medications with prompting/supervision. (Exhibit D-3)

8) At the time of the PAS, the Appellant was assessed as Level 1 Self/Prompting in the areas of *eating, bathing, dressing,* and *grooming.* (Exhibit D-3)

9) The November 18, 2024 PAS indicated the Appellant is Level 1 – Continent. (Exhibit D-3)

10) At the time of the PAS, the Appellant was Level 1 – *oriented.* (Exhibit D-3)

11) The November 18, 2024 PAS indicated the Appellant has the ability to transfer independently. (Exhibit D-3)

12) At the time of the PAS, the Appellant was Level 2 – supervised/assistive device in the area of *walking,* and Level 1 – w*heeling*. (Exhibit D-3)

13) The November 18, 2024 PAS indicated the Appellant is able to vacate the building independently. (Exhibit D-3)

14) At the time of the PAS, the Appellant did not require skilled needs in *suctioning, tracheostomy, ventilator, parenteral fluids, sterile dressings,* or *irrigations.* (Exhibit D-3)

15) The physician's recommendation on the November 18, 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 of Medical Services (BMS) Manual § 514.5.2, provides, in part:

> 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 § 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

BMS Manual § 514.5.4 provides, in part:

> All individuals admitted or requesting admission to a Medicaid certified nursing facility must be screened for the possible presence of a mental illness, and/or an Intellectual/Developmental Disability (I/DD). This review is identified as the Level I (PAS) evaluation. Any individual identified with the possible presence of mental health issues must be further evaluated in the Level II PASRR.

BMS Manual § 514.5.5 provides, in part:

> If the Level I evaluation found the possible presence of mental illness and/or I/DD, further evaluation of the individual must be completed to obtain a definitive diagnosis and the need for specialized services for the mental health condition. This evaluation is identified as a Level II evaluation and must be completed by an individual identified by the State as an approved Level II evaluator. All Level II evaluators are either licensed psychologists or Board-Certified psychiatrists.
>
> It is the responsibility of the facility in which the PAS is completed, to arrange for the Level II evaluation. This evaluation must be completed, including a report of the mental health status and whether specialized services are needed, within seven to nine calendar days following the referral. The Level II must be completed prior to the individual's admission into a nursing facility. Upon completion of the evaluation, both the referring entity and the PASARR Level II evaluator must provide the complete mental health evaluation and the original Level I evaluation to the receiving nursing facility.

DISCUSSION

Pursuant to policy, all Long-Term Care (LTC) programs require a determination of medical eligibility. To qualify medically for the nursing facility Medicaid benefit, 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. Per policy, the Appellant must have five (5) functional deficits at the time the PAS was completed in order to qualify medically for nursing facility services. Acentra, the Utilization Management Contractor (UMC) responsible for conducting medical necessity reviews of the PAS, assessed the Appellant with zero (0) deficits. On November 20, 2024, a Notice of Denial for continued LTC Medicaid benefits was issued advising that the Appellant did not meet the five (5) functional deficit threshold as required by policy to qualify for nursing facility services. The Respondent had to demonstrate by a preponderance of evidence that the UMC followed policy in determining the Appellant's medical eligibility for continued LTC Medicaid benefits.

During the hearing, the Appellant's Representative testified that the Appellant has had numerous hospital admissions (14) since September 2017 due to chest pain, shortness of breath, and low levels of oxygen. She further testified that the Appellant is in "chronic heart and respiratory failure," and has an "enlarged heart." The Appellant's Representative testified that she feels as if the Appellant would not be able to vacate in an emergency, administer his own medications, or have the ability to self-administer his oxygen due to his intellectual disability. The Respondent testified that the medical eligibility screening process is a two-step process. The Level I process determines medical eligibility only. If the individual is determined to be medically eligible for a nursing facility level of care, and the individual presents a diagnosis of intellectual disability, the individual must undergo a Level II evaluation to determine if placement in a nursing facility is appropriate. However, even though the Appellant's PAS did not meet the nursing facility medical eligibility requirements at Level I, a Level II screening indicated "Nursing Facility services not needed."

The Board of Review cannot make clinical determinations regarding the Appellant's functional ability and can only determine if the Respondent correctly followed the policy when deciding the Appellant's Medicaid LTC benefit eligibility at the time of the PAS. To be eligible for a deficit in the functional areas of *eating, 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 four (4) 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 1 – no wheelchair, in the functional area of *wheeling*. Therefore, deficits in the areas of *walking* and *wheeling* cannot be awarded.

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's Representative provided testimony that she's unsure if the Appellant would have the intellectual capacity to vacate without assistance, the PAS indicates that the Appellant has the ability to vacate "independently" and that he "ambulates throughout the facility independently with an assistive device." Therefore, a deficit in the area of *vacating* cannot be awarded.

At the time of the November 2024 PAS, the Appellant was evaluated not having a decubitus, being able to administer his own medications with prompting/supervision, having the ability to transfer, and not requiring skilled needs in *suctioning, tracheostomy, ventilator, parenteral fluids, sterile dressings*, or *irrigations.* It should also be noted that the physician documented the Appellant's length of stay as "On the basis of present medical findings, the individual may eventually be able to return home or be discharged: Yes – Please specify estimated length of stay (in calendar days): 30," which is consistent with the evidence and testimony presented at the time of the hearing. Because the preponderance of the evidence revealed the Appellant did not have severe functioning deficits in any areas at the time of the PAS, the Respondent's decision to deny the Appellant continued eligibility for Medicaid LTC was correct.

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 did not have any deficits that met the severity criteria at the time of the November 2024 PAS.

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 continued Medicaid LTC benefits.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to deny the Appellant's November 18, 2024, application for Long-Term Care (LTC) Medicaid benefits.

ENTERED this _____ day of January 2025.

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Angela D. Signore
State Hearing Officer