February 4, 2025

REMOVED

RE: REMOVED v. WV DoHS/BMS
ACTION NO.: 24-BOR-3859

Dear REMOVED

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,

Tara B. Thompson, MLS
State Hearing Officer
Member, State Board of Review

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

cc: Kesha Walton, Bureau for Medical Services
Terry McGee II, Bureau for Medical Services
REMOVED Appellant's Relative
REMOVED Appellant's Relative
REMOVED Appellant's Relative

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

REMOVED

Appellant,

v. **Action Number: 24-BOR-3859**

WEST VIRGINA 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 REMOVED 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 January 16, 2025.

The matter before the Hearing Officer arises from the Respondent's November 12, 2024 decision to deny the Appellant's medical eligibility for Medicaid Long-Term Care admission.

At the hearing, the Respondent was represented by Terry McGee, II, Bureau for Medical Services. Appearing as a witness for the Respondent was Melissa Grega, RN, Acentra. The Appellant appeared and was represented by REMOVED and REMOVED relatives who share authority to make the Appellant's medical decisions. Appearing as witnesses for the Appellant were REMOVED and REMOVED the Appellant's relatives. All witnesses were sworn, and the following documents were admitted into evidence.

Department's Exhibits:
D-1 Acentra Health Notice of Denial for Long-Term Care, dated November 12, 2024
D-2 Acentra Health summaries of BMS Manual Chapter 514 Nursing Facility Services excerpts
D-3 Pre-Admission Screening (PAS), submitted November 7, 2024
D-4 REMOVED Health and Rehabilitation Medication Review 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) On August 13, 2016, the Appellant was admitted to the REMOVED Health & Rehabilitation (hereafter, Facility) under the care of REMOVED MD, (hereafter, REMOVED) (Exhibit D-4).

2) The Appellant's sisters, REMOVED and REMOVED, retain the Medical Power of Attorney (MPOA) to make the Appellant's medical decisions.

3) On November 12, 2024, Acentra Health issued a notice advising the Appellant her request for Long-Term Care admission was denied because the submitted PAS failed to identify five (5) areas of care that met severity eligibility criteria (Exhibit D-1).

4) The November 12, 2024 notice did not identify the presence of any areas of care that met severity eligibility criteria (Exhibit D-1).

Pre-Admission Screening

5) On May 22 and November 7, 2024, the Facility submitted a Pre-Admission Screening (PAS) on behalf of the Appellant (Exhibit D-3).

6) The Facility's physician, REMOVED, completed the May 22 and November 7, 2024 PAS forms (Exhibit D-3).

7) Under Item 19 on the May 22, 2024 PAS, REMOVED indicated the Appellant had assigned MPOA and indicated under *specify*, "HAS WV COMBINED MPOA AND LIVING WILL." Whereas, on the November 7, 2024 PAS, REMOVED left all categories blank (Exhibit D-3).

8) Under Item 20 *Health Assessment* on the May 22, 2024 PAS, REMOVED checked the box certifying that the attached document contained the Appellant's most recent health assessment data, whereas on the November 7, 2024 PAS, the box was not checked (Exhibit D-3).

9) Under Item 21 *Normal Vital Signs for the Individual* on the May 22, 2024 PAS, REMOVED completed *height, weight, blood pressure, temperature, pulse, respiratory rate,* and checked *Musculo Skeletal* as abnormal.

10) Under Item 21 *Normal Vital Signs for the Individual* on the November 7, 2024 PAS, REMOVED left *height, weight, blood pressure, temperature, pulse,* and *respiratory rate* blank. He checked *ears* and *skin* as abnormal (Exhibit D-3).

11) Under Item 23 *Medical conditions/symptoms* on the May 22, 2024 PAS, REMOVED indicated *severe* for *significant arthritis, pain*, and *diabetes*. He indicated *mild* for *mental disorders*.

12) Under Item 23 *Medical conditions/symptoms* on the November 7, 2024 PAS, REMOVED indicated *moderate* for *significant arthritis* and *mental disorders*. He indicated *mild* for *pain* and *diabetes* (Exhibit D-3).

13) Under Item 24 *Does the applicant have a decubitus?* REMOVED marked *No* on both the May 22 and November 7, 2024 PAS (Exhibit D-3)

14) Under Item 25 *In the event of an emergency, the individual can vacate the building*, on the May 22, 2024 PAS, REMOVED marked *Mentally Unable*; whereas, on the November 7, 2024 PAS, REMOVED marked *Independently* (Exhibit D-3).

15) Under Item 26(a) *Eating*, REMOVED marked *Level 1- Self/Prompting* on the May 22 and November 7, 2024 PAS forms (Exhibit D-3).

16) At the time of the November 7, 2024 PAS, the Appellant had an active order for a regular textured diet with regular/thin consistency (Exhibit D-4).

17) At the time of the November 7, 2024 PAS, the Appellant had an active order reflecting, "May go off of therapeutic diet on special occasions/events. Diet textures will be provided per physician order" (Exhibit D-4).

18) Under Item 26 (b) *Bathing*, (c) *Dressing*, and (d) *Grooming*, REMOVED marked *Level 2- Physical Assistance* on the May 22, 2024 PAS; whereas, on the November 7, 2024 PAS, REMOVED marked *Level 1- Self/Prompting* (Exhibit D-3).

19) Under Item 26 (e) *Continent/Bladder*, on the May 22 and November 7, 2024 PAS forms, REMOVED marked *Level 2- Occasional Incontinent* (Exhibit D-3).

20) Under Item 26 (f) *Continent/ Bowel*, on the May 22, 2024 PAS, REMOVED marked *Level 1- Continent*; whereas, on the November 7, 2024 PAS, REMOVED marked *Level 2- Occasional Incontinent* (Exhibit D-3).

21) Under Item 26 (g) *Orientation* on the May 22, 2024 PAS, REMOVED marked *Level 2- Intermittent Disoriented*; whereas, on the November 7, 2024 PAS, REMOVED marked *Level 1- Oriented* (Exhibit D-3).

22) Under Item 26 (h) *Transferring* and (i) *Walking* on the November 7, 2024 PAS, REMOVED marked *Level 1- Independent* (Exhibit D-3).

23) Under Item 26 (j) *Wheeling* on the May 22 and November 7, 2024 PAS, REMOVED marked *Level 1- No Wheelchair* (Exhibit D-3).

24) Under Item 26 (k) *Vision* on the May 22, 2024 PAS, REMOVED marked *Level 3- Impaired/Not correctable*; whereas, on the November 7, 2024 PAS, REMOVED marked *Level 2- Impaired/Correctable* (Exhibit D-3).

25) Under Item 26 (l) *Hearing* on the May 22, 2024 PAS, REMOVED marked *Level 1- Not Impaired;* whereas, on the November 7, 2024 PAS, REMOVED marked *Level 2- Impaired/Correctable* (Exhibit D-3).

26) Under Item 26 (m) *Communication* on the May 22, 2024 PAS, REMOVED marked *Level 2-Impaired/Understandable*; whereas, on the November 7, 2024 PAS, REMOVED marked *Level 1- Not Impaired*.

27) Under Item 27 *Professional and technical care needs* on the May 22 and November 7, 2024 PAS, REMOVED left all areas blank (Exhibit D-3).

28) Under Item 28 *Individual is capable of administering his/her own medications* on the May 33 and November 7, 2024 PAS, REMOVED marked *with prompting supervision* (Exhibit D-3).

29) At the time of the PAS, the Appellant was prescribed *Basaglar KwikPen Solution Pen-injector 1—UNIT/ML (Insulin Glargine)*: "Inject 35 unit subcutaneously one time a day for diabetes" (Exhibit D-4).

30) Under Item 30 *Current Diagnosis* on the May 22, 2024 PAS, REMOVED checked: *f. other developmental disabilities, Mild Intellectual Disaiblity; k. Affective Bipolar disorder; m. Major Depression;* and *n. other related conditions*, which included Bipolar Disorder; Borderline Personality Disorder; Obsessive Compulsive Disorder; Insomnia, Manic Episode; and Generalized Anxiety Disorder.

31) Under Item 30 *Current Diagnosis* on the November 7, 2024 PAS, REMOVED checked: *f. other developmental disabilities, Mild Intellectual Disability; m. Major Depression;* and *n. other related conditions*, which included Bipolar Disorder; Borderline Personality Disorder; Obsessive Compulsive Disorder; Mild Intellectual Disabilities; Generalized Anxiety Disorder; Major Depressive Disorder; and Manic Episode (Exhibit D-3).

32) Under *IV Physician Recommendation*, Item 35 *Prognosis*, on the May 22 and November 7, 2024 PAS, REMOVED checked "stable" (Exhibit D-3).

33) Under Item 36 *Rehabilitative Potential*, on the May 22, 2024 PAS, REMOVED checked "limited;" whereas, on the November 7, 2024 PAS, REMOVED checked "good" (Exhibit D-3).

34) Under Item 38. *Physician Recommendations*, on the May 22, 2024 PAS, REMOVED checked "For Nursing Facility Placement Only" and indicated that the Appellant would not eventually be able to return home or be discharged. REMOVED recommended that

the services and care to meet the Appellant's needs could be provided at the nursing home level of care.

35) Under Item 38 *Physician Recommendations*, on the November 7, 2024 PAS, REMOVED checked, "For Nursing Facility Placement Only" and indicated that the Appellant would eventually be able to return home or be discharged (Exhibit D-3). REMOVEDindicated the Appellant's estimated length of stay was 90 days (Exhibit D-3). REMOVED recommended that the services and care to meet the Appellant's needs could be provided at the nursing home level of care.

36) Under Item 39 — *To the best of my knowledge, the patient's medical and related needs are essentially as indicated above*, REMOVED applied a typed name beside *Physician Signature*. REMOVEDapplied a check mark beside, *Checking this box certifies that the MD/DO name, typed into the "Physician's Signature" field is the Physician who completed this PAS form. Also checking this box certifies this PAS form will be completed with the MD/DO signature for this applicant and is on file in the applicant's record* (Exhibit D-3).

APPLICABLE POLICY

Bureau for Medical Services (BMS) Manual § 514.5.3 ***Medical Eligibility Regarding Pre-Admission Screening*** provides that to medically qualify 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 PAS form, to be utilized for physician certification of the medical needs of individuals applying for Medicaid benefits. The PAS 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 …."

When a PAS is submitted electronically, the physician has two options for providing attestation that the patient's medical and related needs are accurate as indicated with their signature:

If the physician has the capability for electronic signature (an actual version of their signature, such as when one signs for a credit card or package, the signature is created electronically), not just a typed version of their name; OR Box #39 will be checked on the PAS which certifies the physician has completed this PAS (his or her name will be typed out). Then the PAS MUST be printed off and the physician's physical signature (such as the signature you see when one signs a letter) must be added. The signed page is attached to the electronic record and/or sent to the nursing facility accepting the resident.

On either option for signature, the date is automatically populated and that will be the date for the start of Medicaid reimbursement for services, if the individual meets financial eligibility for the nursing facility benefit. However, the PAS must be signed either electronically or physically by the physician for the PAS to be valid.

To qualify for nursing facility Medicaid benefit, an individual must have a minimum of five deficits identified on the PAS. 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

Code of Federal Regulations 42 CFR 483.10(d) *Choice of attending physician* provides that the resident has the right to choose his or her attending physician.

(1) The physician must be licensed to practice, and …

(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.

Code of Federal Regulations 42 CFR 483.20 *Resident assessment* provides that the facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. …

(c) *Quarterly review assessment.* A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.

(g) *Accuracy of assessments*. The assessment must accurately reflect the residents' status.

DISCUSSION

The Respondent denied the Appellant's medical eligibility for Medicaid Long-Term Care (LTC) benefits because the PAS did not identify the presence of severe deficits in five functioning areas. During the hearing, the Appellant's representative argued that that Appellant's functioning has not improved, and she should be found eligible for Medicaid LTC benefits.

The Board of Review cannot judge the policy and can only determine if the Respondent followed the policy when deciding the Appellant's Medicaid LTC benefit eligibility denial. Further, 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 deficits that were present at the time of the PAS. The Hearing Officer may not make clinical determinations about the Appellant's medical improvement and can only determine whether the submitted reliable evidence demonstrated the presence of five functioning deficits that met severity criteria at the time of the PAS.

To verify that the Appellant was correctly denied eligibility, the preponderance of evidence had to demonstrate that the Appellant did not have deficits in five functioning areas at the time of the PAS.

PAS Reliability

The federal regulations require the Facility to conduct periodic assessments of the Appellant's functional capacity that accurately reflect the resident's status. The BMS Manual provides that the assessment tool must be completed, signed, and dated by a physician certifying that the patient's medical and related needs are essentially as indicated within. The regulations require the assessment to accurately reflect the residents' status. According to the regulations, a physician may certify the assessment by electronic signature.

The Board of Review may only consider information relevant to the Appellant's functional abilities at the time of the PAS. While the Appellant's representatives and witnesses presented the previous PAS as evidence of the Appellant's functioning discrepancy, the regulations require updated evaluations to be completed to determine ongoing eligibility.

Pursuant to the regulations, the Appellant has the right to choose her attending physician. The evidence revealed that REMOVED has been the Appellant's physician since her admission to the Facility in August 2016. As the Appellant is unable to make her own medical decisions, she has appointed two relatives with the authority of MPOA to facilitate her medical decision making.

The evidence revealed that the November 7, 2024 PAS was electronically signed by REMOVED certifying that the Appellant's needs are as indicated within the PAS. The Appellant's representatives and witnesses argued that the PAS did not accurately reflect the Appellant's functioning limitations.

Although testimony regarding the Appellant's functioning at the time of the November 7, 2024 PAS was compelling and it is plausible for the PAS to reflect a physician error, no corroborating medical reports or other documentary evidence were presented to establish a discrepancy in the Appellant's functioning at the time of the PAS. As no other relevant medical records were presented to invalidate REMOVED assessment, the reliability of the PAS cannot be ruled out. Therefore, the PAS must be considered when determining whether the Appellant's eligibility was correctly denied.

The Appellant submitted the May 2024 PAS with her hearing request and disagreed with the functioning improvement reflected on the November 7, 2024 PAS. On November 7, 2024 PAS, there were areas left blank. The May 22, 2024 PAS reflected the Appellant's combined MPOA and living will; whereas, the November 7, 2024 PAS was left blank in this area. The May 22, 2024 PAS reflected that REMOVED checked the box certifying the Appellant's most recent health assessment data was attached to the PAS; whereas, the November 7, 2024 PAS was left unchecked in this area. The May 22, 2024 PAS reflected that REMOVEDcompleted the vital signs portion of assessment question; whereas, the November 7, 2024 PAS was left blank in these areas. Upon reviewing the record, the Hearing Officer found the incomplete boxes were not relevant portions for determining Medicaid Long-Term Care admission eligibility. The absence of information would only make the document unreliable if the missing information was required to be included for establishing eligibility by the controlling policies.

Pre-Admission Screening

To be eligible for Medicaid Long-Term Care admission, the PAS had to identify the presence of five severe functioning deficits at the time of the PAS. The policy provides that eligibility is determined by the responses to questions #24 through #28 on the PAS.

According to the policy, stage 3 or 4 decubitus constitutes a qualifying severe deficit. The submitted testimony and documentary evidence indicated that the Appellant did not have a decubitus at the time of the PAS, therefore a severe deficit could not be identified for *decubitus*.

To have a severe deficit identified in *vacating*, the Appellant had to be mentally or physically unable to vacate the building in the event of an emergency. The PAS reflected that the Appellant was able, with supervision, to vacate the building during an emergency. Vacating independently or with supervision is not considered a deficit as defined by the policy.

To have a severe deficit in *eating, bathing, grooming,* or *dressing*, the Appellant had to be assessed as Level 2 — physical assistance, or higher. Under *eating*, REMOVED marked *Level 1- Self/Prompting* on the May 22 and November 7, 2024 PAS. Under *bathing, dressing,* and *grooming*, REMOVEDindicated *Level 1,* that the Appellant was able to complete these tasks independently or with prompting. As the preponderance of evidence failed to establish that the Appellant required physical assistance, severe deficits could not be identified for *eating, bathing, grooming* or *dressing*.

To receive a deficit for *continence*, the Appellant had to be assessed as Level 3 or higher – totally incontinent. On the May 22 and November 7, 2024 PAS, REMOVED marked *Level 2- Occasional Incontinent* of bladder. The November 7, 2024 PAS indicated the Appellant was *Level-2- Occasional Incontinent* of bowel. As the preponderance of evidence failed to establish that the Appellant was totally incontinent of bladder or bowel, a severe deficit could not be identified for *continence*.

To receive a deficit for *orientation*, the client must be assessed as Level 3 - totally disoriented or comatose. While testimony provided that the Appellant lacked healthcare decision making capabilities, the submitted information was not sufficient to verify that the Appellant was totally

disoriented or comatose at the time of the PAS. On the PAS, REMOVED indicated the Appellant was *Level 1-Oriented*. As the preponderance of evidence failed to establish that the Appellant was totally disoriented or comatose, a severe deficit could not be identified for *orientation*.

To receive deficits for *transferring* and *walking*, the Appellant had to be assessed as Level 3 or higher — one or two-person assistance, or higher. On the November 7, 2024 PAS, REMOVED marked Level-1 *independent*. As the preponderance of evidence failed to establish that the Appellant required physical assistance in these areas, a severe deficit could not be identified for *transferring* or *walking*.

To receive a deficit for *wheeling*, the Appellant had to be assessed as Level 3 or higher. The PAS reflected that the Appellant did not use a wheelchair. As the Appellant did not require a wheelchair at the time of the PAS, a severe deficit could not be identified for *wheeling*.

Under Item 26, *vision*, *hearing*, and *communication* are not eligible deficit areas for establishing eligibility. Severe deficits may only be considered for the areas identified by the policy.

To receive a deficit for *skilled needs*, the Appellant had to require suctioning, tracheostomy, ventilator, parenteral fluids, sterile dressings, or irrigation care. On the November 7, 2024 PAS, REMOVED left all areas blank. As the preponderance of evidence failed to establish that the Appellant required one of the professional and technical care needs listed, a severe deficit could not be identified for this area.

To receive a deficit for *medication administration*, the Appellant had to be assessed as incapable of administering her own medications. The submitted records did not reflect any orders indicating the Appellant was incapable of administering her own medications. As the Appellant's physician conducted the PAS and assessed the Appellant as capable of administering her own medications, the preponderance of evidence failed to establish that a severe deficit should be identified for this area.

The physician recommended nursing home placement only for 90 days, which is reasonably consistent with the stable prognosis and assessment that the Appellant would be able to return home or be discharged. While the physician recommended nursing home placement, the physician's recommendation did not establish that the Appellant presented five severe functioning deficits at the time of the PAS, as is required for establishing Medicaid LTC eligibility.

Because the preponderance of evidence failed to reveal the presence of severe functioning deficits at the time of the PAS, the Respondent's decision to deny the Appellant medical eligibility for Medicaid LTC was correct.

CONCLUSIONS OF LAW

1) To be eligible for Medicaid Long-Term Care, the Appellant had to have five areas of care deficits that met severity criteria at the time of the November 7, 2024 PAS.

2) The preponderance of evidence revealed that the Appellant had no severe functioning deficits at the time of the PAS.

3) Because the Appellant did not have five areas of care deficits that met severity criteria at the time of the PAS, the Respondent correctly denied the Appellant's Medicaid LTC eligibility.

DECISION

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

ENTERED this 4th day of January 2025.

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Tara B. Thompson, MLS
State Hearing Officer