STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF THE INSPECTOR GENERAL

Jeffrey H. Coben, M.D.
Interim Cabinet Secretary

Board of Review
416 Adams Street Suite 307
Fairmont, WV 26554
304-368-4420 ext. 30018
Tara.B.Thompson@wv.gov

Sheila Lee
Interim Inspector General

January 6, 2023

[redacted]

RE: [redacted] v. WVDHHR
ACTION NO.: 22-BOR-2528

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 Board of Review is governed by the Public Welfare Laws of West Virginia and the rules and regulations established by the Department of Health and Human Resources. 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 that may be taken if you disagree with the decision reached in this matter.

Sincerely,

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

Enclosure: Decision Recourse
Form IG-BR-29

CC: Terry McGee, II, Bureau for Medical Services
Lori Tyson, Bureau for Medical Services

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Appellant,

v. **ACTION NO.: 22-BOR-2528**

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES,

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 of Chapter 700 of the West Virginia Department of Health and Human Resources' (DHHR) Common Chapters Manual. This fair hearing was convened December 13, 2022 on an appeal filed with the Board of Review on November 29, 2022.

The matter before the Hearing Officer arises from the Appellant's protest to the Respondent's October 5, 2022 decision to deny the Appellant's medical eligibility for Medicaid Long-Term Care admission.

At the hearing, the Respondent appeared by Terry McGee, II, Bureau for Medical Services (BMS). Appearing as a witness for the Respondent was Melissa Grega, RN, KEPRO. The Appellant appeared *pro se*. All witnesses were sworn in and the following exhibits were entered as evidence.

Department's Exhibits:
D-1 Evidence List; Medicaid LTC Denial Letter, dated October 5, 2022
D-2 Bureau for Medical Services (BMS) Policy Excerpt
D-3 Pre-Admission Screening (PAS), dated October 5, 2022
D-4 [redacted] Center Records
D-5 [redacted] Center Progress Notes, dated April 15 through September 16, 2022

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 following Findings of Fact are set forth.

FINDINGS OF FACT

1) On April 14, 2022, the Appellant was admitted to [redacted] Center (hereafter Facility) (Exhibit D-5).

2) On October 5, 2022, the Respondent issued a notice advising the Appellant her request for Medicaid Long-Term Care admission had been denied because the Pre-Admission Screening (PAS) form failed to reflect the presence of at least five areas of care deficits that met criteria (Exhibit D-1).

3) The PAS established that the Appellant had deficits in the areas of *medication administration* and *bathing* (Exhibit D-1).

4) On October 5, 2022, the [redacted] Center physician, [redacted] completed a PAS with the Appellant (Exhibit D-3).

5) At the time of the PAS, the Appellant was able to vacate the building independently in the case of emergency (Exhibit D-3).

6) The Appellant was assessed as Level 1-Self/Prompting in the areas of *eating, dressing,* and *grooming* (Exhibit D-3).

7) At the time of the PAS, the Appellant had an active order for colostomy appliance care (Exhibit D-4).

8) The Appellant was incontinent at the time of the PAS (Exhibit D-4).

9) The Appellant was assessed as *oriented* (Exhibit D-3).

10) The Appellant was assessed as Level 1-Independent in the areas of *transferring* and *walking* (Exhibit D-3).

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

12) The PAS reflected that the Appellant's prognosis was stable and her rehabilitative potential was good (Exhibit D-3).

13) The physician's recommendations included nursing facility placement with a 60-day estimated length of stay (Exhibit D-3).

APPLICABLE POLICY

Bureau for Medical Services (BMS) Manual §§ 514.5.1 and 514.5.3 (Effective July 1, 2020) provide in pertinent parts:

> The medical eligibility determination is based on a physician's assessment of the medical and physical needs of the individual … The Pre-Admission Screening (PAS) must contain the signature of a physician who has knowledge of the individual and certify the need for nursing facility care.
>
> An individual must have a minimum of five deficits identified on the PAS. These deficits may be any of the following:
>
> - #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)
>   - 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 or two person assistance)
>   - Walking: Level 3 or higher (one person assistance)
>   - Wheeling: Level 3 or higher (must be level 3 or 4 on walking)
> - #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 own medications.
>
> The assessment must be completed, signed, and dated by a physician. The physician may apply an electronic signature or check Box #39 and apply a physical signature. The signed page is attached to the electronic record.

DISCUSSION

The Respondent determined the Appellant did not meet eligibility criteria for Medicaid LTC benefits because the PAS failed to identify the presence of deficits in five functioning areas. The Appellant disagrees with the Respondent's denial of her eligibility for Medicaid LTC benefits. The Appellant did not contest any specific areas of the PAS.

The Respondent bears the burden of proof. The Respondent had to prove by a preponderance of the evidence that the Appellant did not have deficits in five functioning areas at the time of the

PAS. The notice indicated the presence of two deficits, in the areas of *medication administration* and *bathing*.

The evidence established that the Appellant was incontinent and required use of a colostomy appliance at the time the PAS was completed. The Appellant should have received a deficit on the PAS in the area of *continence*. Although the Appellant testified that she has barriers moving her left hand and feeling her feet, the Appellant did not indicate that she should have been awarded deficits in any other functioning area.

The Respondent is required to rely on information contained in the PAS for physician certification of the Appellant's medical needs.The evidence revealed that the same physician that completed the PAS completed progress evaluations of the Appellant on April 15, May 17, and July 12, 2022. While the physician failed to reflect the Appellant's colostomy appliance on the PAS, no evidence was entered to indicate that the other information provided in the PAS was unreliable.

During the hearing, the Appellant argued that she requested help from the Facility to apply for Social Security Administration (SSA) benefits and housing. The Appellant testified that she was independent and able to get around but needed assistance traveling to SSA to apply for benefits. The Appellant argued that the Facility was supposed to assist her with getting her colostomy reversed. Although the Appellant requires assistance with these matters, the policy does not reflect a deficit area for these needs.

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 PAS.

2) At the time of the PAS, the Appellant had deficits in the areas of *medication administration* and *bathing.*

3) The preponderance of evidence revealed that the Appellant should have received a deficit on the PAS in the area of *continence.*

4) Because the preponderance of evidence reflected that the Appellant had only three areas of care deficits that met severity criteria at the time of the PAS, the Respondent correctly denied the Appellant's eligibility for Medicaid Long-Term Care.

DECISION

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

ENTERED this 6th day of 2023.

_____

Tara B. Thompson, MLS
State Hearing Officer