Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2179331
Decision Date:	3/08/2022	**Hearing Date:**	01/11/2022
Hearing Officer:	Scott Bernard	**Record Open to:**	01/18/2022

Appearance for Appellant:
[redacted]

Appearance for ASAP:
Kathleen Sheehan *via* telephone
Anne Mitchell, RN *via* telephone

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
100 Hancock Street, Quincy, Massachusetts 02171

APPEAL DECISION

Appeal Decision:	Denied	**Issue:**	Long Term Care Services Screening
Decision Date:	3/08/2022	**Hearing Date:**	01/11/2022
ASAP's Rep.:	Kathleen Sheehan; Anne Mitchell, RN	**Appellant's Rep.:**	*Pro se*
Hearing Location:	Quincy Harbor South		

Authority

This hearing was conducted pursuant to Massachusetts General Laws Chapter 118E, Chapter 30A, and the rules and regulations promulgated thereunder.

Jurisdiction

Through a notice dated October 19, 2021, Greater Springfield Senior Services, Inc. Aging Services Access Point (the ASAP) determined that the appellant was not clinically eligible for MassHealth payment of nursing-facility service, because those services were not medically necessary. (See 130 CMR 456.409 and Exhibit 1, pp. 3-4). An appeal of this notice was filed in a timely manner on December 6, 2021. (See 130 CMR 610.015(B) and Ex. 1, p. 1; See also EOM 20-09). Individual MassHealth agency determinations regarding scope and amount of assistance (including, but not limited to, level-of-care determinations) are valid grounds for appeal. (See 130 CMR 610.032).

At the conclusion of the hearing, the record was left open until January 18, 2022 for the appellant to submit information.

Action Taken by ASAP

The ASAP determined that appellant was not clinically eligible for MassHealth coverage of nursing facility services on a long-term basis.

Issue

The appeal issue is whether the ASAP was correct, pursuant to 130 CMR 456.409 in determining that the appellant did not meet the nursing home admission criteria for nursing facility services on a long-term basis.

Summary of Evidence

The ASAP received a short-term review screen request from the nursing facility on October 15, 2021. (Ex. 4, pp. 3-4). The appellant is an individual who is over the age of 65. (Ex. 4, p. 5). A review of the appellant's file showed that the appellant had the following diagnoses: diabetes mellitus type 2 without complications; history of COVID-19 upon admission; pneumonia due to COVID-19; major depressive disorder; anemia; glaucoma; irritable bowel syndrome with diarrhea; obesity; hypertension; idiopathic gout; radial styloid tenosynovitis (De Quervain); general weakness; adult failure to thrive; and unsteadiness on feet. (Ex. 4, pp. 5-6). The ASAP representatives stated that the appellant received nursing care and treatment in the form of medication monitoring and administration as *per* facility policy. The appellant's functional status was as follows: she occasionally uses her walker independently for mobility; she was continent of bladder and bowel; she was independent with all activities of daily living (ADLs). The ASAP representatives noted that the appellant's mental status was reported as alert and oriented.

On October 18, 2021, an ASAP nurse and case manager made an on-site assessment of the appellant. (Ex. 3, Ex. 4, p. 27). During the assessment, the appellant expressed understanding concerning the reason for the visit. The ASAP assessment team informed the appellant that the review screen would be processed as a denial because the documentation noted that the appellant was independent with all her ADLs. (See also Ex. 4, pp. 14-23). The appellant confirmed that she was able to manage all of her own care and would be able to manage her medications in the community. The appellant also was no longer using oxygen. The ASAP assessment team advised the appellant of her right to appeal the denial decision and that the paperwork with directions on how to file the appeal would accompany the denial she would receive. The appellant was not upset and expressed understanding that if she appealed and lost, she would be responsible for paying the nursing facility for any additional time she was at the facility. The ASAP assessment team explained to the appellant that a hearing officer with the MassHealth Board of Hearings would issue a decision concerning the appeal. As stated above the denial notice was sent to the appellant on October 19, 2021. (Ex. 1, pp. 3-4; Ex. 4, pp. 1-2). The appellant subsequently appealed this denial in a timely manner as also stated above. (Ex. 1, p. 1).

On January 3, 2022, an ASAP nurse made a follow-up visit to the appellant in anticipation of the January 11, 2022 hearing. (Ex. 3; Ex. 4, p. 26). The reason for the follow-up was to determine if there had been any changes to the appellant's status. While visiting the appellant in her room, the nurses observed the appellant moving around her bed changing the sheets. When the ASAP nurse asked if she changed the sheets all on her own the appellant replied that she did change them by herself. The ASAP representative explained to the appellant that the visit was to determine if there were any changes to her status in anticipation of the appeal hearing. The appellant reported she was able to perform all ADLs by herself including showering. The appellant then stated that she had severe headaches on a daily basis. The appellant informed the ASAP nurse that the facility's nurses give her medication for this. The appellant stated that she has applications in for housing in two nearby towns and did not care where she ended up. The ASAP nurse informed the appellant that the appeal hearing would take place telephonically and the resident and indicated that she understood. A staff nurse at the facility informed the ASAP nurse that the appellant had applied to a local affordable senior community but had been

denied admission. The staff nurse stated that she did not know the reason the affordable senior community denied the appellant's application.

The appellant testified that she continued to have severe headaches. The appellant stated that she had had COVID-19. The appellant stated that she woke up with headaches every morning. The appellant also stated that she had dizziness that accompanied the headaches. It was because of the dizziness that she depended on her walker. The appellant stated that outside of this she was independent. The appellant then stated that the nurses at the facility had begun administering medication for her headache by injection in her neck. The appellant did not know when she began receiving this particular medication, however, and did not know the name of the medication. The appellant stated that the medication was prescribed by a neurologist. The appellant stated that she could have the facility submit documentation concerning the injected medication to the Board after the hearing. The appellant stated that she continued to look for housing and was waiting for responses.

The ASAP representatives stated that they were not aware of any injectable medications included on the list of the appellant's medication. They stated that according to the list, the appellant was prescribed one 100 mg carbamazepine tablet per day for her headaches. (Ex. 4, p. 11). The ASAP representatives confirmed that this medication was not injectable but was a chewable tablet. The ASAP representatives stated that it was a bit of a grey area as to whether an injectable medication required the services of a skilled nurse in a nursing facility. They did state that administration of injectable medication could be performed in the community.

The record was left open until January 18, 2022 for the appellant to submit information concerning the injected medication. No further information was submitted by January 18, 2022, and the record closed at that time.

Findings of Fact

Based on a preponderance of the evidence, I find the following:

1. The ASAP received a short-term review screen request from the nursing facility on October 15, 2021. (Testimony of the ASAP representatives; Ex. 4, pp. 3-4).

2. The appellant is an individual who is over the age of 65. (Testimony of the ASAP representatives; Ex. 4, p. 5).

3. A review of the appellant's file showed that the appellant had the following diagnoses: diabetes mellitus type 2 without complications; history of COVID-19 upon admission; pneumonia due to COVID-19; major depressive disorder; anemia; glaucoma; irritable bowel syndrome with diarrhea; obesity; hypertension; idiopathic gout; radial styloid tenosynovitis (De Quervain); general weakness; adult failure to thrive; and unsteadiness on feet. (Ex. 4, pp. 5-6).

4. The appellant received nursing care and treatment in the form of medication monitoring and administration as *per* facility policy. (Testimony of the ASAP representatives).

5. The appellants functional status was as follows: she occasionally uses her walker independently for mobility; she was continent of bladder and bowel; she was independent with all ADLs. (Testimony of the ASAP representatives).

6. The appellant's mental status was reported as alert and oriented. (Testimony of the ASAP representatives).

7. On October 18, 2021, an ASAP nurse and case manager made an on-site assessment of the appellant. (Ex. 3, Ex. 4, p. 27).

    a. During the assessment, the appellant expressed understanding concerning the reason for the visit. (Testimony of the ASAP representatives).

    b. The ASAP assessment team informed the appellant that the review screen would be processed as a denial because the documentation noted that the appellant was independent with all her ADLs. (Testimony of the ASAP representatives; See also Ex. 4, pp. 14-23).

    c. The appellant confirmed that she was able to manage all of her own care and would be able to manage her medications in the community. (Testimony of the ASAP representatives).

    d. The appellant also was no longer using oxygen. (Testimony of the ASAP representatives).

    e. The ASAP assessment team advised the appellant of her right to appeal the denial decision and that the paperwork with directions on how to file the appeal would accompany the denial she would receive. (Testimony of the ASAP representatives).

    f. The appellant was not upset and expressed understanding that if she appealed and lost, she would be responsible for paying the nursing facility for any additional time she was at the facility. (Testimony of the ASAP representatives).

    g. The ASAP assessment team explained to the appellant that a hearing officer with the MassHealth Board of Hearings would issue a decision concerning the appeal.

    h. The ASAP sent the appellant the denial notice under appeal on October 19, 2021. (Ex. 1, pp. 3-4; Ex. 4, pp. 1-2).

    i. The appellant subsequently appealed this denial in a timely manner as also stated above. (Ex. 1, p. 1).

8. On January 3, 2022, an ASAP nurse made a follow-up visit to the appellant in anticipation of the January 11, 2022 hearing. (Ex. 3; Ex. 4, p. 26).

    a. The reason for the follow-up was to determine if there had been any changes to the appellant's status. (Testimony of the ASAP representatives).

    b. While visiting the appellant in her room, the nurses observed the appellant moving around her bed changing the sheets. (Testimony of the ASAP representatives).

c. When the ASAP nurse asked if she changed the sheets all on her own the appellant replied that she did change them by herself. (Testimony of the ASAP representatives).

d. The ASAP representative explained to the appellant that the visit was to determine if there were any changes to her status in anticipation of the appeal hearing. (Testimony of the ASAP representatives).

e. The appellant reported she was able to perform all ADLs by herself including showering. (Testimony of the ASAP representatives).

f. The appellant then stated that she had severe headaches on a daily basis. (Testimony of the ASAP representatives).

g. The appellant informed the ASAP nurse that the facility's nurses give her medication for this. (Testimony of the ASAP representatives).

h. The appellant stated that she has applications in for housing in two nearby towns and did not care where she ended up. (Testimony of the ASAP representatives).

i. The ASAP nurse informed the appellant that the appeal hearing would take place telephonically and the resident and indicated that she understood. (Testimony of the ASAP representatives).

j. A staff nurse at the facility informed the ASAP nurse that the appellant had applied to a local affordable senior community but had been denied admission. (Testimony of the ASAP representatives).

k. The staff nurse stated that she did not know the reason the affordable senior community denied the appellant's application. (Testimony of the ASAP representatives).

9. The appellant continues to have headaches every morning accompanied by dizziness. (Testimony of the appellant).

10. The appellant confirmed that she does not have difficulty with ADLs. (Testimony of the appellant).

11. The appellant reported that she has a pain medication that is injected by the nurses at the facility into her neck. (Testimony of the appellant).

12. Injectable pain medication is not listed amongst the appellant's medications. (Testimony of the ASAP representatives).

13. The record was left open until January 18, 2022 for the appellant to submit proof to the Board of Hearings and the ASAP representatives that she is receiving the reported injection. (Hearing Record).

14. No evidence concerning the injection was received on January 18, 2022 or thereafter. (Hearing

Record).

Analysis and Conclusions of Law

Under 130 CMR 456.408(A), MassHealth pays for nursing-facility services if all the following conditions are met:

(1) MassHealth or its agent has determined that individuals aged 22 and older meet the nursing-facility services requirements of 130 CMR 456.409 or that the medical review team coordinated by the Department of Public Health has determined that individuals aged 21 or younger meet the criteria of 130 CMR 519.006(A)(4).
(2) MassHealth or its agent has determined that community care is either not available or not appropriate to meet the individual's needs.
(3) The requirements for preadmission screening at 130 CMR 456.410 have been met.

The service requirements for medical eligibility for nursing home services are contained in 130 CMR 456.409, which state the following:

> To be considered medically eligible for nursing-facility services, the member or applicant must require one skilled service listed in 130 CMR 456.409(A) daily or the member must have a medical or mental condition requiring a combination of at least three services from 130 CMR 456.409(B) and (C), including at least one of the nursing services listed in 130 CMR 456.409(C).
>
> (A) Skilled Services. Skilled services must be performed by or under the supervision of a registered nurse or therapist. Skilled services consist of the following:
> (1) intravenous, intramuscular, or subcutaneous injection, or intravenous feeding;
> (2) nasogastric-tube, gastrostomy, or jejunostomy feeding;
> (3) nasopharyngeal aspiration and tracheostomy care, however, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled services;
> (4) treatment and/or application of dressings when the physician has prescribed irrigation, the application of medication, or sterile dressings of deep decubitus ulcers, other widespread skin disorders, or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, burns, open surgical sites, fistulas, tube sites, and tumor erosions);
> (5) administration of oxygen on a regular and continuing basis when the member's medical condition warrants skilled observation (for example, when the member has chronic obstructive pulmonary disease or pulmonary edema);
> (6) skilled-nursing observation and evaluation of an unstable medical condition (observation must, however, be needed at frequent intervals throughout the 24 hours; for example, for arteriosclerotic heart disease with congestive heart failure);
> (7) skilled nursing for management and evaluation of the member's care plan when underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. The complexity of the unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the member's recovery and safety;

(8) insertion, sterile irrigation, and replacement of catheters, care of a suprapubic catheter, or, in selected residents, a urethral catheter (a urethral catheter, particularly one placed for convenience or for control of incontinence, does not justify a need for skilled-nursing care). However, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled-nursing care. In such instances, the need for a urethral catheter must be documented and justified in the member's medical record (for example, cancer of the bladder or a resistant bladder infection);
(9) gait evaluation and training administered or supervised by a registered physical therapist at least five days a week for members whose ability to walk has recently been impaired by a neurological, muscular, or skeletal abnormality following an acute condition (for example, fracture or stroke). The plan must be designed to achieve specific goals within a specific time frame. The member must require these services in an institutional setting;
(10) certain range-of-motion exercises may constitute skilled physical therapy only if they are part of an active treatment plan for a specific state of a disease that has resulted in restriction of mobility (physical-therapy notes showing the degree of motion lost and the degree to be restored must be documented in the member's medical record);
(11) hot pack, hydrocollator, paraffin bath, or whirlpool treatment will be considered skilled services only when the member's condition is complicated by a circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications; and
(12) physical, speech/language, occupational, or other therapy that is provided as part of a planned program that is designed, established, and directed by a qualified therapist. The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve specific goals within a given time frame.

(B) Assistance with Activities of Daily Living. Assistance with activities of daily living includes the following services:
(1) bathing when the member requires either direct care or attendance or constant supervision during the entire activity;
(2) dressing when the member requires either direct care or attendance or constant supervision during the entire activity;
(3) toileting, bladder or bowel, when the member is incontinent of bladder or bowel function day and night, or requires scheduled assistance or routine catheter or colostomy care;
(4) transfers when the member must be assisted or lifted to another position;
(5) mobility/ambulation when the member must be physically steadied, assisted, or guided in ambulation, or be unable to propel a wheelchair alone or appropriately and requires the assistance of another person; and
(6) eating when the member requires constant intervention, individual supervision, or direct physical assistance.

(C) Nursing Services. Nursing services, including any of the following procedures performed at least three times a week, may be counted in the determination of medical eligibility:

(1) any physician-ordered skilled service specified in 130 CMR 456.409(A);
(2) positioning while in bed or a chair as part of the written care plan;
(3) measurement of intake or output based on medical necessity;
(4) administration of oral or injectable medications that require a registered nurse to monitor the dosage, frequency, or adverse reactions;
(5) staff intervention required for selected types of behavior that are generally considered dependent or disruptive, such as disrobing, screaming, or being physically abusive to oneself or others; getting lost or wandering into inappropriate places; being unable to avoid simple dangers; or requiring a consistent staff one-to-one ratio for reality orientation when it relates to a specific diagnosis or behavior as determined by a mental-health professional;
(6) physician-ordered occupational, physical, speech/language therapy or some combination of the three (time-limited with patient-specific goals);
(7) physician-ordered licensed registered nursing observation and/or vital-signs monitoring, specifically related to the written care plan and the need for medical or nursing intervention; and
(8) treatments involving prescription medications for uninfected postoperative or chronic conditions according to physician orders, or routine changing of dressings that require nursing care and monitoring.

The appellant has not shown by a preponderance of the evidence that she has need of nursing facility level of care at the time. The record does not demonstrate that the appellant receives any skilled services performed by or under the supervision of a registered nurse or therapist. Although the appellant reported that she receives an injection, there was no evidence of such an injection in the list of prescribed medications. The appellant was given an opportunity after the hearing to provide evidence that such a medication was being administered to her, but the appellant did not submit such evidence. The ASAP representatives also reported that the appellant does not have a problem with performing any ADLs, which the appellant confirmed in her testimony.

For the above stated reasons, the appeal is DENIED.

Order for ASAP

None.

Notification of Your Right to Appeal to Court

If you disagree with this decision, you have the right to appeal to Court in accordance with Chapter 30A of the Massachusetts General Laws. To appeal, you must file a complaint with the Superior Court for the county where you reside, or Suffolk County Superior Court, within 30 days of your receipt of this decision.

Scott Bernard
Hearing Officer
Board of Hearings

cc:

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